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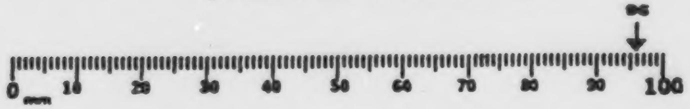

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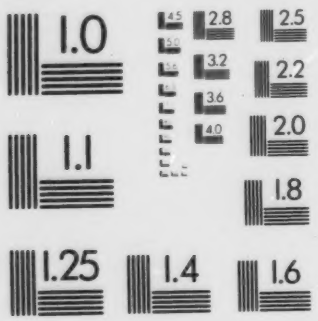

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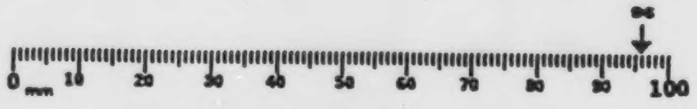

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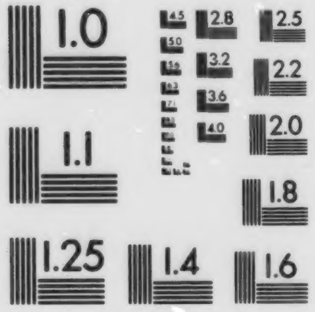

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LAW REFORM
COMMISSION
OF
NOVA SCOTIA

Mental Health Provisions of the Hospitals Act

Law Reform Commission of Nova Scotia
February 2002

102-04209/

FINAL REPORT

MENTAL HEALTH PROVISIONS OF THE HOSPITALS ACT

Law Reform Commission of Nova Scotia
February 2002

The Law Reform Commission of Nova Scotia was established in 1991 by the Government of Nova Scotia under an *Act to Establish an Independent Law Reform Commission*.

The Commissioners are:

Gregory North, Q.C., Co-President
Dawn Russell, Q.C., Co-President
David A. Cameron
Theresa Forgeron
Justice David MacAdam

John E.S. Briggs, B.A., LL.B., is Executive Director and General Counsel of the Commission. William Laurence, B.A., LL.B., LL.M., M.L.I.S., is Legal Research Counsel. Franca Iussa is Administrative Assistant. Anne Jackman, B.Sc., LL.B., LL.M., was Executive Director of the Commission until May 2001. Karen McEwen, LL.B., Legal Researcher with the Commission from January to October 1999, conducted research and consultations during the earlier stages of the project.

The Commission's work is available on the Internet at <www.lawreform.ns.ca>.

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Law Reform Commission of Nova Scotia

To: The Honourable Michael G. Baker, Q.C.
Minister of Justice and Attorney General

In accordance with section 12(3) of the *Law Reform Commission Act*, we are pleased to present the Commission's Final Report on mental health provisions of the *Hospitals Act*.

Gregory North, Q.C.
Co-President

Dawn Russell

Dawn Russell, Q.C.
Co-President

David Cameron
Commissioner

Theresa Forgeron
Commissioner

Justice David MacAdam
Commissioner

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LAW REFORM COMMISSION OF NOVA SCOTIA

SUMMARY OF FINAL REPORT ON

MENTAL HEALTH PROVISIONS OF THE *HOSPITALS ACT*

In December 1997, the Nova Scotia government referred the review of the *Hospitals Act* to the Law Reform Commission of Nova Scotia. The *Hospitals Act* governs psychiatric facilities in Nova Scotia, and in particular, how people are admitted to psychiatric facilities, what rights and entitlements they have on admission, the conditions of their stay, and how they are discharged. At the time of receiving the reference, the Commission was fully engaged on a number of projects, including another government reference. The Commission's prior commitments, as well as the near-closure of the Commission in 2001, delayed work on this project.

The Commission's Final Report describes the main features of the *Hospitals Act*, discusses issues relating to mental health law in Nova Scotia, and recommends what aspects of the *Hospitals Act* should be amended, as well as what sections should remain unchanged. What follows is a summary of the Final Report and its most significant recommendations.

THE CURRENT LAW

Admission to a psychiatric facility

A psychiatric "facility" is defined in the *Act* as a hospital or part of a hospital "used for the observation, care and treatment of persons suffering from psychiatric disorder." In this Report, a psychiatric disorder is defined as a severe mental health problem usually associated with impaired functioning due to a biological, chemical, genetic, physical, psychological, or social disturbance.

A person can be admitted to a psychiatric facility in two ways, with consent (voluntary admission) or without consent (involuntary admission). For voluntary admission, in addition to the person's consent, a qualified physician must indicate that the person requires "in-patient" services at the facility. An in-patient remains at a facility 24 hours a day, in order to receive medical and nursing attention, until discharged. Involuntary admission of a person to a psychiatric facility usually takes place on the basis of two medical certificates issued by physicians, each of whom has examined the person. The medical certificates must state that the physician has reasonable and probable grounds to believe that the person suffers from a psychiatric disorder, and that the person should be admitted because he or she needs in-patient services and requires care that cannot be adequately provided outside the facility, because he or she is a danger to his or her own safety or the safety of others.

One is admitted as a "person for observation" with respect to most routes of entry under the *Hospitals Act*. A person under observation is admitted to a facility for the purpose of a medical examination and psychiatric assessment. A psychiatric assessment involves the determination of the presence or absence of a psychiatric disorder. A person may remain under observation for up to seven days. After expiry of the observation period, the person may be discharged, or may remain in a facility as a voluntary or involuntary patient. A voluntary patient remains in a facility as long as the patient consents and a physician recommends the patient's continued admission. Once declared an involuntary patient, a person may be detained in a facility for an initial detention period of up to one month. An involuntary admission certificate may be renewed to extend the period of detention for two successive periods of up to three months each and thereafter for periods up to six months in duration. The detention of a patient under an involuntary admission certificate lasts, subject to statutory time limits, until the patient is discharged by a psychiatrist, the Supreme Court of Nova Scotia, or the Psychiatric Facilities Review Board.

Treatment

The *Hospitals Act* requires a person to be examined within three days of admission to a facility in order to have determined his or her capacity to consent to treatment. Mental capacity is an individual's ability to make reasoned decisions after weighing the risks, benefits, and other factors. After the examination, the psychiatrist must complete a "declaration," which states whether in the psychiatrist's opinion the person examined is capable of consent to treatment. In general, no treatment may be administered without consent unless the person does not have the capacity to consent. Treatment can, however, proceed even in the face of a refusal if the person is deemed incapable of consenting to the treatment, and if consent of a "substitute decision-maker" is obtained. A substitute decision-maker or "proxy" is a person appointed to make a health care decision on behalf of someone else. A substitute decision-maker can be appointed through an "advance health care directive," a legal document in which a person sets out how his or her health care is to be managed in the event of mental incapacity. Appointment of a substitute decision-maker can also occur under authority of the *Hospitals Act* or of a guardianship order.

Patients' property and finances

Competency to administer one's financial affairs is also decided by a psychiatrist. Similar to a capacity declaration, upon completion of an examination, the psychiatrist must provide a declaration concerning the examined person's competency to administer his or her estate, that is, everything that a person owns.

Review of decisions

If a patient believes that a decision affecting him or her was wrong or unfair, he or she can apply to have the decision "reviewed" or reconsidered, by a decision-maker external to the facility. The Psychiatric Facilities Review Board has the authority to review declarations involving capacity or competency, as well as issues involving detention, treatment, or care. For all issues, with the exception of treatment or care, the review board has the power to make a binding order. For treatment or care, the review board can only make recommendations. The Supreme Court of Nova Scotia can review an involuntary patient's status upon application by the patient or his or her representative. The Supreme Court may also review declarations of capacity or competency.

Rights and protections under the *Hospitals Act*

The *Hospitals Act* specifies a number of rights and protections for persons who are compulsorily examined, persons under observation, and patients. These provisions specify the criteria upon which certain *Hospitals Act* decisions are to be reached, set time limits on the effects of those decisions, and identify what recourses are available to people who disagree with a decision that affects them.

The *Hospitals Act* includes protections relating to examination and assessment, admission to a facility, treatment, the length of stays at a facility, challenges to *Hospitals Act* decisions, discharge from a facility, legal representation, communications, and confidentiality of health information.

RECOMMENDATIONS

In September 2000, the Commission published a Discussion Paper, *Mental Health Provisions of the* Hospitals Act, which contained the Commission's preliminary suggestions on reform of the *Hospitals Act*. The Discussion Paper generated a significant amount of commentary. Having taken into account the comments received, the Commission makes a number of recommendations, which include the following:

- The term "mental disorder" should be used rather than "psychiatric disorder." "Mental disorder" should be defined as a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life.

- The *Hospitals Act* should continue to allow for the involuntary admission of a person for observation on the basis of two medical certificates provided by physicians. Admission for observation should also be possible based upon one certificate where the attending physician is able to justify why only one certificate was used.

- The Nova Scotia legislation should allow for the involuntary admission of someone with a mental disorder when "serious harm" is likely to self or others.

- The standard time period for completion of a psychiatric examination should not exceed 48 hours.

- Peace officers should be permitted to leave a facility during the time that a person apprehended and brought in by the officers is being assessed. To avoid any misunderstandings, consent for peace officers to depart a facility should be in writing.

- Facility staff should be required to inform peace officers prior to discharge when a psychiatric examination is completed and a person who had been brought to a facility by peace officers is not admitted as an involuntary patient.

- An admission certificate should be renewable for a period not to exceed one month, followed if needed by a period not to exceed two months, in turn followed by a period not to exceed three months. Any additional renewal periods would be for periods not to exceed three months.

- The *Hospitals Act* should require that prior to receiving a particular treatment, a patient must provide his or her informed consent. This would mean that the patient was informed about the nature of the treatment, its expected benefits, its material risks, its material side effects, any alternative courses of action, and any likely consequences of not having the treatment.

- The *Hospitals Act* should state explicitly that every person is considered capable of making treatment decisions, until the contrary is determined. A capacity determination should take place on an as-needed basis, in accordance with generally accepted medical practices.

- In addition to psychiatrists, other specially qualified health care professionals should be permitted to complete capacity assessments. Organizations of health care professionals should determine what combination of training and experience would allow someone to meet the required qualifications.

- A substitute decision-maker should be required to take into account any prior expressed wishes by a person. If there are no prior expressed wishes, or if they are unclear, then a substitute decision-maker should take a person's best interest, which would be defined in the statute, under account.

- The statute should specifically allow for treatment to be administered without consent to a person who is incapable with respect to consent to the treatment, if there is an emergency.

- The *Hospitals Act* should include a section which exempts from liability any person acting reasonably and in good faith in the course of his or her responsibilities under the *Act*.

- Where a person is no longer mentally capable, an advance health care directive should be overridden, if medical developments, not known at the time of the directive's creation, are sufficiently compelling to justify not following the directive.

- Leave certificates should be made available in Nova Scotia for certain involuntary patients. In order for a leave certificate to be issued, the patient must be suffering from a mental disorder for which he or she needs continuing treatment or care and supervision while living in the community. The patient must be considered likely, because of the mental disorder, to cause serious harm to self or others if the patient does not receive continuing treatment or care and supervision while living in the community. A collaborative treatment plan must be developed, to which the patient or the patient's representative consents. The conditions which led to the issuance of a leave certificate should be subject to review, and the duration of a leave certificate should be defined.

- A sitting review board should consist of a lawyer, a psychiatrist, and a lay person. Training should be provided for all review board appointees. Training should include an introduction to mental health concepts and issues which might likely arise as part of a review board hearing. Training should also include the requirements of natural justice, fairness, human rights law, and modern caseflow management practices.

- Review boards should provide written reasons with their decisions. A decision with reasons should be communicated to the parties involved as soon as possible, and in any event, within five calendar days of the hearing.

- The *Hospitals Act* should provide for a rights adviser at each psychiatric facility. A rights adviser would be entrusted with the responsibility of explaining a matter pertaining to rights to the best of his or her ability in a manner that addresses the special needs of the person receiving the explanation. A rights adviser should be knowledgeable about rights of application to a review board, the nature and procedures of the review boards, and how to obtain legal services.

- If a facility wishes to deny a patient access to his or her health record, either in whole or part, then the *Hospitals Act* should require the facility to apply for a review board hearing, at which the facility would have to convince the board why denial of access would be reasonable.

- The Public Trustee, as an objective third party, could be called upon to ensure that a patient's interests are protected at a hearing involving the possible denial of access to health information.

- The disclosure of the relevant portion of the patient's health record should be possible to any person if the keeper of the record reasonably believes that the disclosure is necessary to prevent or lessen a serious and immediate threat to the mental or physical health or the safety of the individual who is the subject of the information, another individual, or public health or safety.

- The *Hospitals Act* should permit a patient, otherwise entitled to view his or her health record, to require that corrections be made, or statements of disagreement be added, to a record.

I INTRODUCTION

1. The project

By letter dated December 18, 1997, the Minister of Justice and Attorney General formally referred the study of mental health law reform to the Law Reform Commission. The Minister stated:

> *Upon request of the Minister of Health, and pursuant to section 8(2) of the* Law Reform Commission Act, *S.N.S. 1990, c. 17, I refer to the Law Reform Commission for its review and advice the mental health provisions of the* Hospitals Act, *R.S. 1989, c. 208, to be dealt with in the usual course.*

The mental health provisions of the *Hospitals Act* govern psychiatric facilities in Nova Scotia, and in particular, how people are admitted to psychiatric facilities, what rights and entitlements they have on admission, the conditions of their stay, and how they are discharged.

In December 1997, at the time it received this reference, the Commission was fully engaged on another government reference concerning reform of the *Probate Act*, as well as a project on mortgages and another on enduring powers of attorney. When initial research for the *Hospitals Act* reference was completed, from January to March 1999, it included consultations, either in person or by telephone, with numerous people having expertise in mental health matters. The Commission extends its thanks to all people who participated in consultations with Commission staff.

From the community, Commission staff held discussions with the Self Help Connection, the Metro chapter of the Schizophrenia Society of Nova Scotia, and the local branch of the Canadian Mental Health Association. Discussions were also held with a number of mental health volunteers.

From the health facility sector, staff met with a number of administrative officers from the Nova Scotia Hospital, including the Executive Director, the Director of Professional Services, the Director of Community Relations & Communications, and the Director of the Provincial Forensic Psychiatric Unit. In addition, staff met with patient representatives at the Nova Scotia Hospital and with the in-house legal counsel for the Queen Elizabeth II (QE II) Health Sciences Centre in Halifax. A meeting was held with a number of social workers involved with both in-patient and out-patient mental health services at the QE II Health Sciences Centre. Consultations were also held with a number of psychiatrists, including the Clinical Director of Mental Health Services at the Cape Breton Health Care Complex and the Head of the Psychiatry Department at the QE II Health Sciences Centre.

From government, meetings were held with staff from the Mental Health Services Division, Nova Scotia Department of Health, and with the Chairs of the Psychiatric Facilities Review

Board. The province's Public Trustee was consulted, and staff spoke by telephone with the Director of the Advisory Council for the Status of Women.

From the legal community, staff met with lawyers from the Dalhousie University Legal Aid service, with legal counsel, both present and past, from the Department of Health, and with Dalhousie University Law School's instructor in mental health law.

To further help in the identification of relevant issues, in June 1999, the Commission formed an Advisory Group, consisting of people with particular knowledge or concerns relating to mental health law. A list of Advisory Group members is provided at **Appendix B**. The Advisory Group included representatives from government, mental health organizations, including consumer groups, health care professionals, the aboriginal community, universities, and law enforcement. Some members of the Advisory Group had also been consulted as part of the Commission's initial research in early 1999. The group met 12 times from June to October 1999. The Commission is grateful for the contributions of the Advisory Group members.

Advisory Group meetings were largely devoted to discussing an Issues Memorandum which Commission staff had prepared. The Issues Memorandum summarized mental health law in Nova Scotia and identified potential issues that might be taken into account when considering the reform of the *Hospitals Act*. Not surprisingly, given the nature of debate that characterizes much of mental health law, Advisory Group discussions demonstrated a wide range of often conflicting perspectives. For many issues, there was little consensus among Advisory Group members. The Commission took note of those issues upon which the Advisory Group had achieved consensus, as well as the variety of perspectives expressed in relation to the other issues in the Issues Memorandum.

The Commission acknowledges with thanks the contributions and suggestions of Advisory Group members. Ultimately, of course, it is the Commission which has the responsibility of deciding what will be incorporated into a Commission Report. We note that for many of the issues addressed in the Issues Memorandum, there was no consensus among Advisory Group members, and therefore no clear, single direction was available for the Commission.

In September 2000, the Commission published a Discussion Paper, *Mental Health Provisions of the Hospitals Act*, which contained the Commission's preliminary suggestions for reform of mental health law in Nova Scotia. One of the most significant changes suggested in the Discussion Paper related to involuntary admission to a psychiatric facility, commonly known as "civil commitment." Civil commitment is usually based on two medical certificates issued by physicians. A medical certificate must state that a person suffers from a psychiatric disorder and needs in-patient services because he or she is a danger to his or her own safety or the safety of others. Implicitly the danger would involve bodily harm. The majority of the Commission suggested, however, that the statute should also allow involuntary admission not only based on bodily harm, but also, if applicable, based on the possibility of psychological harm.

Furthermore, the Commission suggested, civil commitment should be possible based on a person's "imminent and serious impairment" if he or she does not receive treatment.

The Commission also suggested that the use of "leave certificates" was an appropriate measure to implement in Nova Scotia for those involuntary patients who are capable of complying with the certificates' requirements. The Commission suggested that this treatment option would free certain people from the intrusiveness of compulsory hospitalization, thereby allowing them to assume more normal lives in the community.

Among its other Discussion Paper suggestions, the Commission proposed: neither harm to property nor finances should be a ground for civil commitment; a person should be presumed to be mentally capable and a capacity determination should take place only when an issue arises about a patient's capacity; and the *Act* should provide for a patients' rights adviser at each psychiatric facility. The Discussion Paper also suggested numerous changes relating to review and appeal of decisions made in the context of civil commitment, as well as the confidentiality of health care records. A list of suggestions in the Discussion Paper is provided at **Appendix A** to this Final Report.

The Discussion Paper generated a significant amount of commentary, by letter, by e-mail, by telephone, and in person. A list of those persons who commented on the Discussion Paper is found at **Appendix B**. The Commission is grateful for the commentators' feedback. Opinions expressed concerning the Discussion Paper suggestions tended to vary widely. For example, the Discussion Paper in general was described by some commentators as "important and well-written," "well-researched, thoughtful," and "an excellent document that addresses many long-standing concerns." On the other hand, other commentators used such terms as "very threatening and reactionary," "paternalistic," and "technical and limited in nature" to describe the Discussion Paper.

Publication of this Final Report was delayed by the likelihood that the Commission would have to close in 2001. In April 2000, the Commission was informed that after March 31, 2001, it would no longer receive government funding. As the government portion accounted for 60% of the Commission's funding, and no other sizeable sources of funding were apparent, it seemed that the Commission would have to close. In the period from the spring of 2000 to the spring of 2001, Commission staff devoted considerable time and energy alternately attempting to keep the Commission operating, and trying to complete a number of projects prior to the Commission's closure. Fortunately, in February 2001 the Commission received a three-year grant of full funding from the Law Foundation of Nova Scotia. This funding meant that the Commission could continue its law reform work, including its review of the *Hospitals Act*. Since the announcement of new funding in February 2001, the Commission has been required to examine certain issues involving its long-term viability. Without recent funding disruptions, the Commission is confident that it would have completed this project far earlier than occurred.

Having taken into account the comments received, and where appropriate, having completed additional research, the Commission has prepared this Final Report.

2. Definitions

This Final Report attempts to present legal information as clearly as possible so that people who do not have legal training can understand the Commission's recommendations for reform. As some of the language relates to specific legal and technical concepts, the words used may not be familiar to everyone. This section provides definitions of such words used in this Report.

Act	-	Law made by elected members of government. Also referred to as "statute" or "legislation."
Action	-	Court proceeding by which a person makes a claim or asserts a right.
Admission certificate	-	Written authority to admit a person as an involuntary patient. Also referred to as "declaration of formal admission."
Advance health care directive	-	A legal document in which a person sets out how his or her health care is to be managed in the event of mental incapacity. The document may appoint a representative, known as a "substitute decision-maker" or "proxy," to make health care decisions, may set out general principles or specific instructions about how a person's health care is to be managed, or may do both.
Advocate	-	Individual who provides support and speaks for another.
Appeal	-	A proceeding to set aside or vary a decision which has been made by another court, tribunal or individual.
Civil commitment	-	Compulsory admission of a person as a patient to a psychiatric facility.
Common law	-	Law developed over the years by judges when making decisions in court. These decisions are relied upon by other judges in making decisions in later cases.
Community treatment order	-	A legal mechanism which provides for the involuntary treatment of a patient who lives in the community, subject to a number of conditions and restrictions.

Declaration of formal admission	-	Written authority to admit a person as an involuntary patient. Also referred to as "admission certificate."
Estate	-	Everything that a person owns.
Formal patient	-	Person whose admission as a patient to a psychiatric facility is compulsory. Also known as "involuntary patient." The process by which one becomes a formal patient is sometimes known as "civil commitment."
Guardian	-	An individual with the right and duty of protecting the person, property, or rights of someone who is not mentally capable or is otherwise unable to manage his or her own affairs.
Indictable offence	-	Generally a more serious criminal offence. An indictment is an accusation in writing of an offence.
Informal patient	-	Person whose admission as a patient to a psychiatric facility is non-compulsory. Also known as "voluntary patient."
Involuntary patient	-	Person whose admission to a psychiatric facility is compulsory. Also known as "formal patient." The process whereby one becomes an involuntary patient is sometimes known as "civil commitment."
In-patient services	-	Services provided within a hospital setting in which a patient stays 24 hours a day, in order to receive medical and nursing attention.
Leave certificate	-	Similar to "community treatment order," a mechanism to allow involuntary patients to return to the community and receive treatment there, but with the consent of a patient or of a patient's representative.
Legislation	-	Law made by elected members of government. Also referred to as "statute" or "act."
Mental capacity	-	An individual's ability to make reasoned decisions after weighing the risks, benefits, and other factors.
Mental health consumer	-	A person who, because of a mental health problem, uses or at some point used, mental health services.

Mental illness or disorder - A severe mental health problem usually associated with impaired functioning due to a biological, chemical, genetic, physical, psychological, or social disturbance.

Parens patriae - Literally "parent of the country" - exclusive jurisdiction of the sovereign over those people perceived unable to manage their own affairs.

Patient - Person admitted to a psychiatric facility for diagnosis, lodging, or treatment. A patient can be "voluntary," also known as "informal," or can be "involuntary," also known as "formal."

Person under observation - Person admitted to a psychiatric facility for the purpose of an examination and psychiatric assessment.

Personality disorder - Longstanding abnormalities of an individual's thinking, feeling, and behaving that create serious problems for the individual, society, or both.

Proxy - Person appointed to make health care decisions on behalf of someone else. Also known as "substitute decision-maker."

Psychiatric assessment - Determination of the presence or absence of a mental illness or disorder.

Psychiatric facility - A hospital or part thereof used for the observation, care and treatment of people with mental illness.

Psychiatric treatment - Treatment to improve the symptoms that cause a person to meet the criteria for involuntary admission.

Psychiatrist - A physician with special training in psychiatry, a body of knowledge associated with the diagnosis and treatment of mental illness.

Public Trustee - A government office that may be appointed to, among other matters, act as guardian of an adult who is found unable to manage his or her own affairs.

Records - Information files kept by individuals, programs and services to document their work with people.

Renewal certificate	-	Authority to extend a person's "involuntary" or "formal" patient status beyond the duration of the original "admission certificate" or the most recent renewal certificate.
Review	-	To reconsider a decision.
Substitute decision-maker	-	Person appointed to make health care decisions on behalf of someone else. Also known as "proxy." Can be appointed by "statute" or by an "advance health care directive."
Statute	-	Law made by elected members of government. Also referred to as "legislation" or "act."
Tribunal	-	Body or person exercising a statutory decision-making power outside the regular court system.
Voluntary patient	-	Person whose admission as a patient to a psychiatric facility is non-compulsory. Also known as "informal patient."

II GENERAL INFORMATION

A. DEVELOPMENT OF CIVIL COMMITMENT LAW

1. Role of the state

The role of the state in taking custody and care of people with mental illness is a long-standing one. In Nova Scotia, the relevant law has its source in an ancient concept, *parens patriae*, which literally means "parent of the country."[1] This concept originated in the law of England at least as long ago as the 13th century.[2] As the highest authority in the land, the sovereign was seen as the natural choice to take care of those people, such as the mentally ill, who were perceived unable to manage their own affairs. The concept was "founded on the obvious necessity that the law should place somewhere the care of persons who are not able to take care of themselves."[3] Otherwise, it was feared, people with mental illness might do injury to themselves or squander their fortunes.[4] *Parens patriae* formed part of the "royal prerogative," a group of rights and capacities enjoyed only by the sovereign.[5] *Parens patriae* gave the sovereign an exclusive jurisdiction over people with mental illness and their property. This jurisdiction was not actually exercised by the sovereign in person, but was delegated to the Lord Chancellor, who was the head of the Court of Chancery.[6]

Mentally disabled people subject to *parens patriae* were traditionally described by the law as either "idiots" or "lunatics."[7] Both were seen as incapable of managing their own interests. An idiot was considered mentally disabled from the time of birth, while a lunatic was someone who developed a mental illness during the course of his or her lifetime.[8]

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[1] J.R. Nolan & M.J. Connolly, *Black's Law Dictionary*, 5th ed. (St. Paul, Minn.: West Publishing, 1979) [hereinafter *Black's Law Dictionary*] at 1003.

[2] G.B. Robertson, *Mental Disability and the Law in Canada*, 2nd ed. (Scarborough, Ont.: Carswell, 1994) at 8.

[3] *Re Eve* (1986), 31 D.L.R. (4th) 1 at 28 (S.C.C.).

[4] B. Murdoch, *Epitome of the Laws of Nova-Scotia*, vol.1 (Halifax: Joseph Howe, 1832-33) at 118.

[5] *Black's Law Dictionary*, note 1, above, at 1195.

[6] *Re Bulger* (1911), 1 W.W.R. 248 at 249 (Man. K.B.). Later on, the jurisdiction was delegated to two Chancery Court judges: Robertson, note 2, above, at 8.

[7] In its reports, the Commission attempts to use language which is respectful and inclusive. In discussing earlier legal concepts, however, it is sometimes necessary to mention terms now considered insensitive or demeaning.

[8] Murdoch, note 4, above, at 118-119.

In Nova Scotia, a Court of Chancery was created by royal authority in 1749.[9] As, however, there was no Lord Chancellor in Nova Scotia, the Governor was chosen to serve as head of the court.[10] The Governor also assumed the royal jurisdiction over people with mental illness.[11] In *R.* v. *Martin*, an 1854 decision, Halliburton, C. J. confirmed the application of *parens patriae* in Nova Scotia: "The Crown as the *parens patriae* is entitled, by its inherent prerogative, to the custody of all insane persons, for the purpose of protecting the community."[12]

2. Statutory approaches

Gradually, the *parens patriae* jurisdiction, which was part of the common law, took the form of statutes created by the Legislature. This part of the Final Report summarizes some of the more significant aspects of those earlier statutes, which have contributed to the development of current legislation concerning psychiatric facilities in Nova Scotia.

In 1759, the Nova Scotia House of Assembly enacted a statute to provide for the establishment of a house of correction or workhouse in Halifax.[13] This institution, commonly referred to as a "bridewell," served as a jail, a reformatory, and place of commitment for people seen as socially undesirable.[14] It was meant not only for pre-trial detention, but also for long-term confinement and punishment, and in particular, hard labour. The groups of people liable to be confined there were varied, including the poor, minor criminals, and people with mental illness.[15] The workhouse was notorious for its cold, damp, and unhealthy conditions.[16]

In early Nova Scotia, therefore, people with mental illness were treated as a social problem. The emphasis in dealing with this problem was on confinement. This was apparent in a 1774 statute titled, *An Act for Punishing Rogues, Vagabonds, and Other Idle and Disorderly*

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[9] C.J. Townshend, *History of the Court of Chancery in Nova Scotia* (Toronto: Carswell, 1900) at 63.

[10] B. Cahill, "*Bleak House* Revisited: The Records and Papers of the Court of Chancery of Nova Scotia, 1751-1855" (1989-90) 29 Archivaria 149 at 150.

[11] Murdoch, note 4, above, vol. 4, at 44.

[12] (1854), 2 N.S.R. 322 at 324 (N.S.C.A.). The sovereign's jurisdiction over people with mental illness was also mentioned by statute: S.N.S. 1774, c. 5, s. 8.

[13] S.N.S. 1759, c. 1.

[14] R. Baehre, "From Bridewell to Federal Penitentiary: Prisons and Punishment in Nova Scotia Before 1880," in P. Girard and J. Phillips, eds., *Essays in the History of Canadian Law*, vol. 3, *Nova Scotia* (Toronto: University of Toronto Press, 1990) 163 at 166.

[15] Note 13, above, ss. 2, 5.

[16] Baehre, note 14, above, at 167.

Persons.[17] This statute, based on British legislation,[18] set out a procedure for apprehending and confining people with mental illness. Where persons were considered to be "furiously mad, and dangerous to be permitted to go abroad," two justices of the peace could order them to "be apprehended, and kept safely locked up in some secure place within the county."[19] The justices also had the power to order that such people be kept chained. Given this reference to dangerousness, the law signalled it was no longer concerned solely with protecting mentally ill people, but also considered it necessary to protect the community from potential harm by certain people with mental illness, a use of the law sometimes now known as the "police power."[20] Although the applicable period of restraint was "such time only as such madness continue[d]," no details were provided about the release of anyone confined in accordance with the statute. Section 8 of the 1774 statute did, however, offer an alternative to confinement, by allowing friends or relatives to take under their care those mentally ill persons who would otherwise have been confined.

In 1792, the House of Assembly provided for the establishment of workhouses outside of Halifax.[21] Separate buildings were not deemed necessary, as a portion of the local jail could be used instead. At the Halifax workhouse, depending on the period in question, a separate building, or an annex to the main building, was sometimes used for people with mental illness; at other times, all residents were housed together.[22] In 1832, a committee from the Nova Scotia House of Assembly visited the Halifax facility. The committee was appalled by the crowded and disease-ridden conditions.[23]

In 1851, the legislature passed the statute, *Of Madmen and Vagrants*.[24] For the most part, this statute retained the features of the 1774 *Act*. The 1851 statute contained no reference, however, to people with mental illness being considered "dangerous." Rather, the statute provided that a "madman" was to be "secured" in his or her legal settlement. Unlike the 1774 *Act*, the 1851 statute did not refer to the duration of a person's confinement. Implicitly, therefore, the detention of people with mental disorders could be indefinite. Detainees could still be chained.

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[17] S.N.S. 1774, c. 5.

[18] M. Kingma, *Mental Health Law: A Critique of the 'Dangerousness' Criterion for Civil Commitment and Some Recommendations for Change* (LL.M. Thesis, Dalhousie University, 1995) [unpublished] at 145.

[19] Note 17, above, s. 7.

[20] J. Gray, M.A. Shone, & P.F. Liddle, *Canadian Mental Health Law and Policy* (Toronto: Butterworths, 2000) at 103.

[21] S.N.S. 1792, c. 5.

[22] A.H. MacDonald, *Mount Hope Then and Now: A History of the Nova Scotia Hospital* ([Dartmouth, N.S.]: The Nova Scotia Hospital, 1996) at 14.

[23] The committee also noted that different categories of residents were not kept apart. See Nova Scotia, *Journal and Proceedings of the House of Assembly* [hereinafter J.H.A.] (1832), App. 49. After a visit in 1845, Assembly members similarly reported overcrowding: J.H.A. (1845), App. 70 at 200.

[24] R.S.N.S. 1851, c. 104.

Until the mid-19th century, there was little change in the state's approach in Nova Scotia to people with mental illness. Statutes emphasized confinement, which tended to take place under deplorable conditions. There was no reference in the legislation to the treatment of people with mental illness, let alone to any rights they might have.

Soon after the passage of the 1851 statute, however, Nova Scotia legislators turned their attention to more appropriate housing and even treatment for people with mental illness.[25] For a number of years, there had been calls from varied interests, including the Medical Society, the Board of Health, newspapers, individual physicians, and concerned citizens, for the establishment of an institution devoted exclusively to the care and treatment of people with mental illness.[26] A former insistence on the "mere safe custody" of people with mental illness was replaced by confidence in the treatability of mental illness, especially if treatment was undertaken early. In the words of a committee report, presented to the House of Assembly in 1845, "[c]orporeal punishment, confinement and chains, [were] no longer considered indispensable - these [had] given way to the vigilant eye of a well qualified attendant."[27] Legislators became aware of developments outside Nova Scotia, particularly in the United States, involving the care and treatment of people with mental illness. The concept of an asylum, meant specifically for the care and treatment of people with mental illness, had developed. With asylums seemingly "sanctioned by the example of every civilized State,"[28] there was a belief that Nova Scotia should not be left behind.

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[25] Also in 1851, the Nova Scotia legislature added another facet to the law relating to people with mental illness, with the passage of the Act, *Of the Custody and Estates of Lunatics*, R.S.N.S. 1851, c. 152. It provided for the guardianship of people with mental illness and care of their property. It did not, however, involve confinement.

[26] C.E. Saunders, *Social Conditions and Legislation in Nova Scotia (1815-1851)* (M.A. Thesis, Dalhousie University, 1949) [unpublished] at 155, 163-164; D. Francis, "The Development of the Lunatic Asylum in the Maritime Provinces" (1977) 6:2 Acadiensis 23 at 28.

[27] J.H.A. (1845), App. 70 at 201.

[28] J.H.A. (1846), App. 32 at 105. See also J.H.A. (1850), App. 18. Asylums, which attempted to treat people with mental illness, rather than simply serve as custodial housing, were first established in North America in the 1830s: G. Andrews, *The Establishment of Institutional Care in Halifax in the Mid-Nineteenth Century* (Honours Essay, Dalhousie University, 1974) [unpublished] at 18.

In 1852, a statute was enacted to provide for the founding of a provincial "lunatic asylum," designed to be a "building fitted for the reception and proper keeping of lunatics and idiots."[29] In 1858, another statute indicated that this institution, to be called the Provincial Hospital for the Insane, would provide "the most humane and enlightened curative treatment of the insane of this province."[30] Preference in admission was for those cases "of most recent occurrence, and hence most likely to be benefitted by hospital treatment."[31] The Provincial Hospital received its first patient at the end of 1858.[32] As the 19th century unfolded, the Provincial Hospital, contrary to expectations, tended to be overcrowded, with neither sufficient staff, nor adequate facilities, to deal with the numbers of patients.[33]

According to an 1858 statute, if an application concerning an "insane person" was made to any two justices of the peace, it was their duty to investigate that person's "insanity" and to commit that person to the county jail, if satisfied "that such person [was], by reason of insanity, unsafe to be at large, or [was] suffering any unnecessary duress or hardship." To determine whether or not a person was "insane" the justices could rely on the assistance of physicians, though this was not necessary.[34] After being committed to the county jail, a person with a mental illness could be transferred to the Provincial Hospital. Two medical certificates were required for admission. These certificates had to be signed by two physicians, who stated that "they [had] personally and separately examined such patient, and believe[d] him or her to be insane."[35] By 1864, the standard form of medical certificate referred to people of "unsound mind" being "detained under care and treatment."[36]

A statute enacted in 1872 renamed the provincial psychiatric facility the Nova Scotia Hospital for the Insane. Patients who had been under care for more than six months in the Nova Scotia Hospital, and who had recovered far enough to enable them to be taken care of in a private family setting, could be discharged on a trial basis into the care of relatives or friends, or could be placed as boarders.[37]

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[29] S.N.S. 1852, c. 13, s. 2.

[30] S.N.S. 1858, c. 38, s. 1.

[31] Note 30, above, s. 15. See also s. 12 of the same statute.

[32] J.H.A. (1859), App. 10 at 162.

[33] MacDonald, note 22, above, at 56, 78; Francis, note 26, above, at 34.

[34] Note 30, above, s. 14; S.N.S. 1855, c. 34, s. 3.

[35] Note 30, above, s. 20.

[36] R.S.N.S. 1864, c. 152, Sch.

[37] S.N.S. 1872, c. 3, ss. 20, 25, 32.

In 1886, the province provided for the establishment of asylums outside Halifax for people with mental illness. These institutions were meant "for the care of the harmless insane, idiotic persons, and epileptic persons who [were] insane but who [had] not manifested symptoms of violent insanity."[38] The county asylum system was not intended to provide treatment.[39] People with mental illness and other groups of people confined there were not necessarily kept apart, as the buildings could be used both as poorhouses and as "lunatic asylums."[40]

Under an 1887 statute, a person who was no longer "insane" could apply to court, to have his or her guardian removed, and to be able to "resume full control of his [or her] person and estate."[41]

In 1900, the name of the provincial psychiatric facility was changed to the Nova Scotia Hospital.[42] In 1909, medical certificates were explicitly made sufficient authority for any person to convey a patient to the provincial hospital and for the medical superintendent at that hospital to detain the patient therein for treatment, until discharged.[43]

The concept of "voluntary patients" was made part of Nova Scotia law in 1912. There was a possibility for voluntary admission of a person to the Nova Scotia Hospital, so long as the person applied in writing, the medical superintendent recommended that person's admission, and there was an order from the Government minister in charge. After they had given written notice of an intention to leave the hospital, voluntary patients were not to be detained more than three days.[44]

In 1944, the police were identified as one of the groups empowered to apprehend and return without warrant any people who left without permission from a local asylum.[45]

In 1960, six procedures were set out for the admission of a patient to the Nova Scotia Hospital: voluntary; by medical certificate; by transfer from a municipal psychiatric facility; by magistrate's order; by virtue of the *Criminal Code*, or certain other federal statutes; or by transfer from a mental hospital in another province or state or from a hospital under federal jurisdiction.[46]

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[38] S.N.S. 1886, c. 44, s. 1.

[39] Nova Scotia, *Report of the Royal Commission on the Halifax County Hospital* ([Kentville, N.S.: Ministry of Public Health], 1970) (Commissioner: H.P. MacKeen) at 15.

[40] Note 38, above, s. 15.

[41] S.N.S. 1887, c. 27, s. 1.

[42] R.S.N.S. 1900, c. 44, s. 1.

[43] S.N.S. 1909, c. 17, ss. 2, 4.

[44] S.N.S. 1912, c. 31, s. 1.

[45] S.N.S. 1944, c. 19, s. 1.

The 1960 statute also provided for the appeal of a decision concerning a patient, on the ground that he or she was "not mentally ill."[47] Patients did not then enjoy this right. Rather, the right to appeal was provided to a relative or a friend of the patient, or to an interested party. In 1967, patients received the right to apply to a court for discharge from the Nova Scotia Hospital.[48] Prior to these provisions, there had been little consideration in Nova Scotia statutes to establishing procedural safeguards to protect the rights of people with mental illness.

Under the 1967 statute, a patient's admission to the Nova Scotia Hospital could last a year and was renewable. Those patients who were considered to have recovered enough to return to the community could benefit from a trial release of up to six months.[49]

The *Hospitals Act* is the current statute which governs psychiatric facilities in Nova Scotia, and in particular, the admission of patients, their rights while at a facility, the conditions of their stay, and how they are discharged. It was enacted in 1977, came into force in 1979, and is now part of the Revised Statutes of Nova Scotia.[50]

B. THE CURRENT LAW

1. The *Hospitals Act*

The *Hospitals Act* is legislation which in part governs the admission, either on a voluntary or involuntary basis, of people to psychiatric facilities in Nova Scotia. A facility is defined in the *Act* as a hospital or part of a hospital "used for the observation, care and treatment of persons suffering from psychiatric disorder."[51] A psychiatric disorder has been defined as a severe mental health problem usually associated with impaired functioning due to a biological, chemical, genetic, physical, psychological, or social disturbance.[52] Unless referring to specific statutory language, this Final Report uses the term "mental illness" or "mental disorder" rather than psychiatric disorder or equivalent terms. The *Hospitals Act* also sets out guidelines concerning the examination, assessment, treatment and discharge from psychiatric facilities of people with mental illness. This part of the Final Report summarizes how people in Nova Scotia are admitted to psychiatric facilities, what rights and entitlements they have on admission, and the conditions of their stay.

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[46] S.N.S. 1960, c. 8, s. 12(3).

[47] Note 46, above, s. 25(1).

[48] S.N.S. 1967, c. 15, s. 28.

[49] Note 48, above, ss. 24-25.

[50] S.N.S. 1977, c. 45; O.I.C. 79-12, N.S. Gaz. 1979.II.7; R.S.N.S. 1989, c. 208. In this report, the term "Nova Scotia legislation" is also used to refer to the *Hospitals Act*. For a discussion of the motivation which may have led to the current statute, see L.E. Rozovsky, "New Developments in Nova Scotia Psychiatric Legislation" (1979) 5 Dalhousie L.J. 505.

[51] *Hospitals Act*, note 50, above, s. 2(d).

2. Admission to a psychiatric facility for observation

A person is admitted as a "person for observation" with respect to most routes of entry under the *Hospitals Act*.[53] A person under observation is admitted to a facility for the purpose of a medical examination and psychiatric assessment. A psychiatric assessment involves the determination of the presence or absence of a mental illness or disorder.[54] A person can be admitted to a psychiatric facility for observation in two ways, namely with or without consent:

a) With consent - voluntary admission:[55]

For a person to be admitted voluntarily to a psychiatric facility for observation, his or her consent is required. A qualified physician must also indicate that the person requires the "in-patient" services provided by the facility.[56] An in-patient is a patient who remains at a facility 24 hours a day, in order to receive medical and nursing attention, until discharged.

b) Without consent - involuntary admission:[57]

i) **Medical certificates** - The involuntary admission of a person to a psychiatric facility for observation can take place on the basis of two medical certificates issued by physicians, each of whom has examined the person. The medical certificates must state that the physician has reasonable and probable grounds to believe that the person suffers from a "psychiatric disorder," and that the person should be admitted because he or she needs in-patient services and requires care that cannot be adequately provided outside the facility, because he or she is a danger to his or her own safety or the safety of others.[58]

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[52] Nova Scotia, Mental Health Review Provincial Committee, *A New Step Forward: Improving Mental Health Services for Children and Youth in Nova Scotia* ([Halifax]: Departments of Health and Community Services, 1998) [hereinafter *A New Step Forward*] at 42, 44.

[53] *Hospitals Act*, note 50, above, s. 34(1).

[54] *A New Step Forward*, note 52, above, at 35.

[55] The *Hospitals Act* refers to voluntary admission as "informal admission." In this Report, the term "voluntary admission" is used instead, as it is more descriptive and its meaning more clear.

[56] *Hospitals Act*, note 50, above, s. 34(4).

[57] Although the *Hospitals Act* uses the term "formal admission," in this Report, the term "involuntary admission" is used instead.

A Provincial Court judge specifically has the power to order a medical examination which can lead to the issuance of medical certificates providing for a person's admission for observation. In addition, if a peace officer believes on reasonable and probable grounds that a person suffers from a psychiatric disorder and is either dangerous or is committing or about to commit an indictable offence, the peace officer may take that person to an appropriate place for a medical examination, which could result in medical certificates being issued.[59]

ii) **Transfer** - A person may be transferred from another psychiatric facility within the province or a person may be transferred to a facility from another facility outside of Nova Scotia.[60]

iii) **Warrant or order** - The *Criminal Code* or another federal or provincial statute may provide grounds for a person's involuntary admission.[61]

3. Status at end of observation period

Every person under observation must be examined by a physician and a psychiatrist within 24 hours and three days, respectively, of admission to the facility. A person may remain under observation for up to seven days. During the observation period, a person who is admitted for observation other than with his or her consent may be detained in a facility and returned there if the person is absent without authorization.[62]

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[58] *Hospitals Act*, note 50, above, s. 36. A "psychiatric disorder" is defined at s. 2(q) of the *Act* to mean "any disease or disability of the mind [including] alcoholism and drug addiction."

[59] An indictable offence is generally a more serious criminal offence. An indictment is an accusation in writing of an offence: J.A. Yogis, *Canadian Law Dictionary* (Hauppauge, N.Y.: Barron's, 1998) at 128. This Report does not specifically address issues concerning admission to psychiatric facilities under the criminal law, which is a matter of federal government jurisdiction. For an introduction, see instead Robertson, note 2, above, at 434-437.

[60] *Hospitals Act*, note 50, above, s. 35(1).

[61] Admission under warrant or order is a confusing part of the *Hospitals Act*. S. 35(2), which refers to admission further to the *Criminal Code* or other statutes, does not refer to observation. It is noteworthy that s. 34(1), which sets out the general rule that admission shall be as a person under observation, is subject to s. 35(2). S. 40 specifically refers to admission as a patient under warrant or order. When considered together, these sections seem to indicate that admission under a warrant or order shall be as an involuntary patient, not as a person under observation. However, if for example, one refers to s. 672.14 of the *Criminal Code*, which provides the authority for a psychiatric assessment of an accused person during a period generally not to exceed 5 days, it appears that this type of admission could be as a person under observation. Greater consistency between the *Hospitals Act* and other statutes, such as the federal *Criminal Code*, would be helpful.

After the expiry of the seven day observation period, the person may be discharged, or the person may remain in a facility as a voluntary or involuntary patient. A voluntary patient remains in a facility as long as the patient consents and a physician recommends the patient's continued admission.[63] The *Hospitals Act* refers to a voluntary patient as an "informal patient."

A person declared to be an involuntary patient must remain in the facility.[64] Under the *Hospitals Act*, an involuntary patient is known as a "formal patient." A person admitted as an involuntary patient is sometimes said to have been "committed" to a facility, with the involuntary admission process referred to as civil commitment. Once declared an involuntary patient, a person may be detained in a facility for an initial detention period which can last up to one month. A declaration of involuntary admission may be renewed to extend the period of detention for two successive periods of up to three months each and thereafter for periods up to six months in duration.[65] The detention of a patient under an involuntary admission certificate lasts, subject to statutory time limits, until the patient is discharged by a psychiatrist, the Supreme Court, or the Psychiatric Facilities Review Board.[66]

4. Decisions made during a person's hospitalization

a) Treatment

Section 51 of the *Hospitals Act* requires a person to be examined within three days of admission to a facility in order to have determined his or her capacity to consent to treatment.[67] The examination is done by a psychiatrist. In making this determination, a psychiatrist must consider:

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[62] *Hospitals Act*, note 50, above, ss. 44(4), 46.

[63] Note 50, above, s. 34.

[64] Note 50, above, ss. 34(5), 46.

[65] Note 50, above, ss. 44(2-3).

[66] Note 50, above, ss. 45(2), 47, 63(a). S. 47 actually refers to the County Court, which has been abolished. Matters formerly heard by the County Court are now, however, heard by the Supreme Court: *An Act to Reform the Courts of the Province*, S.N.S. 1992, c. 16, ss. 1, 5.

[67] Mental capacity is an individual's ability to make reasoned decisions after weighing the risks, benefits, and other factors: *A New Step Forward*, note 52, above, at 36.

i) the person's understanding of the condition for which the treatment is proposed;
ii) the person's understanding of the nature and purpose of the treatment;
iii) the person's understanding of the risks of the treatment;
iv) the person's understanding of the risks in not undergoing the treatment; and
v) the person's condition and the effects of the condition on his or her ability to consent.

After the examination, the psychiatrist must complete a "declaration," which states whether or not in the psychiatrist's opinion the person examined is capable of consent to treatment.[68]

In general, no treatment may be administered without consent unless the person does not have the capacity to consent. Treatment can, however, proceed even in the face of a refusal if the person is deemed incapable of consenting to the treatment, and if consent of a "substitute decision-maker" is obtained. A substitute decision-maker or "proxy" is a person appointed to make health care decisions on behalf of someone else. A substitute decision-maker can be appointed by statute[69] or by an "advance health care directive." An advance health care directive is a legal document in which a person sets out how his or her health care is to be managed in the event of mental incapacity.

b) Property

Competency to administer one's financial affairs is also decided by a psychiatrist, who must consider:

i) the nature and degree of the person's condition;
ii) the complexity of the person's estate;
iii) the effect of the condition upon the person's conduct in looking after his or her estate; and
iv) any other circumstances the psychiatrist considers relevant to the estate, the person and his or her condition.

Similar to a capacity declaration, upon completion of an examination, the psychiatrist must provide a declaration concerning the examined person's competency to administer his or her estate.[70]

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[68] *Hospitals Act*, note 50, above, ss. 52(2), 53.

[69] Note 50, above, s. 54.

[70] Note 50, above, ss. 52(3), 53. The *Hospitals Act* does not specify when a determination of a person's competency to handle his or her own financial matters is to be completed.

5. Review decisions under the *Hospitals Act*

a) Psychiatric Facilities Review Board

Certain decisions concerning a patient in a facility are not necessarily final. Rather, if a patient believes that a decision was wrong or unfair, he or she can apply to have the decision "reviewed" or reconsidered, by a decision-maker external to the facility. The Psychiatric Facilities Review Board has the authority to review declarations involving capacity or competency, as well as issues involving detention, treatment, or care. For all issues, with the exception of treatment or care, the board has the power to make a binding order. For treatment or care, the review board can only make recommendations.[71]

The review board must review the file of a patient when requested by the patient, a person authorized by the patient, the administrator or medical director of the facility where the person is a patient, the administrator of psychiatric mental health services, or the Minister, within one month of the request. A review board may, however, refuse to review a patient's file where it has been reviewed within the previous six months. An involuntary patient's file must be reviewed every six months during the first two years of admission and every twelve months thereafter. However, a review board is also able to review the file of any patient at any time.[72]

Section 66 of the *Hospitals Act* provides a patient or the patient's representative with the right to attend a review hearing involving that patient. The right to attend includes the right to be heard. Within 14 days of a review board hearing, the review board must forward a written decision to the person who requested the review, the patient or the patient's representative, the facility administrator and the administrator of psychiatric mental health services.[73]

b) Nova Scotia Supreme Court

Section 47 of the *Hospitals Act* enables the Supreme Court to review an involuntary patient's status upon application by the patient or his or her representative (guardian, spouse or common law partner, next of kin, or Public Trustee). Upon application by the patient or the patient's representative, the Supreme Court may also review declarations of capacity or competency.[74]

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[71] Note 50, above, s. 63.

[72] Note 50, above, ss. 64-65.

[73] Note 50, above, s. 67.

[74] Note 50, above, s. 58(2).

6. The *Charter* & protections under the *Hospitals Act*

The *Canadian Charter of Rights and Freedoms*[75] is the supreme law of Canada. Every provincial and federal law must comply with it. People may apply to court to determine whether or not a provincial or federal law infringes a right or freedom expressed in the *Charter*; if so, that law may be found to be invalid and therefore of no effect.

A number of *Charter* sections are relevant in the context of civil commitment. Under section 7 of the *Charter*, an individual cannot be deprived of life, liberty or security of the person unless that deprivation is consistent with the principles of fundamental justice. Section 9 guarantees a person the right not to be arbitrarily detained or imprisoned. According to section 10, every person has the right on arrest or detention to be informed promptly of the reasons therefor, as well as the right to retain and instruct a lawyer without delay and to be informed of that right. Section 12 states that a person has the right not be subjected to cruel and unusual treatment or punishment. Under section 15, every person is equal before and under the law and has the right not be discriminated against on the basis of a number of factors, including mental disability.

Charter rights are not absolute. Rather, in accordance with section 1, they are subject to limits. Section 1 requires any limits that are placed on a person's *Charter* rights to be "reasonable and justifiable in a free and democratic society."

The *Hospitals Act* was enacted before the *Charter* was adopted. As a result, some of the statute's provisions may not be consistent with the *Charter*. Whether or not the *Hospitals Act* complies with the *Charter* would have to be decided by a court, not in the abstract, but in light of specific facts, following an application by someone who claims that his or her *Charter* rights have been infringed. The Commission is aware of only one reported case in which the *Hospitals Act* was subjected to a challenge under the *Charter*, and in that case, no decision was reached about any *Charter* non-compliance.[76] For guidance about whether a *Hospitals Act* section infringes the *Charter*, it would likely be helpful to look for cases on similar issues from other parts of Canada.

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[75] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982*, (U.K.), 1982, c.11 [hereinafter the *Charter*].

[76] That decision, *MacNeil* v. *Psychiatric Facilities Review Board* (N.S.) (1996), 149 N.S.R. (2d) 205 (S.C.) involved an application by a patient at a facility for a court ruling that the Psychiatric Facilities Review Board's failure to provide reasons for its decisions violated the patient's *Charter* rights. The Nova Scotia Supreme Court refused to rule on the application, as by the time of the court hearing, the applicant was no longer a patient, and there was no outstanding issue between the parties. The issue of a review board having to provide reasons for its decisions is discussed in more detail at D.6e), below.

In this context, it should be noted that the *Hospitals Act* extends a number of protections to persons who are compulsorily examined, persons under observation, and patients. These provisions specify the criteria upon which certain *Hospitals Act* decisions are to be reached, set time limits on the effects of those decisions, and identify what recourses are available to people who disagree with a decision that affects them. The *Hospitals Act* includes protections relating to examination, admission to a facility, treatment, the length of stays at a facility, challenges to *Hospital Act* decisions, discharge from a facility, legal representation, communications, and confidentiality of health information. *Charter*-based challenges to sections of the *Hospitals Act* would involve a determination of the sufficiency of these protections. The next three paragraphs identify the *Act*'s protective sections, which are discussed in more detail elsewhere in this Report.

Section 36 of the *Hospitals Act* sets out specific criteria for admission by means of medical certificates. Subsection 39(2) provides that an examination pursuant to sections 37 (further to a judge's order) or 38 (following apprehension by a peace officer) is to take place "as soon as practicable" after a person is first detained, and in any event within 24 hours from the time of the first detention. Similarly, a decision made about a person under observation is to be made "as soon as practicable after admission and within seven days after the date of admission." The *Act* identifies factors to be used in determining whether or not a person is capable of consenting to treatment, as well as whether or not a person is competent to administer his or her estate. The statute sets out the general rule that no person admitted to a hospital shall receive treatment unless he or she consents to such treatment. The conditions which must be satisfied before psychosurgery is performed are set out at section 60.

Maximum periods for involuntary admission are identified at section 44. Section 47 permits a person to apply to a court for discharge, and section 58 involves the review of declarations involving capacity or competency by a review board or a court. Further functions of the review board are identified at section 63. The statute provides that a person's capacity or competency is to be periodically examined. Section 62 of the *Act* contains a provision to help prevent conflict of interest on the part of a review board member. Review boards must provide a written decision within 14 days and must maintain a record of each review. The *Hospitals Act* also provides for file reviews, whether compulsory, as described at section 64, or on request, as set out at section 65. Concerning review board hearings, section 66 provides a patient with the right to be notified of the date of the hearing and also provides a patient and if applicable, a patient's representative, with the right to be present at the hearing, the right to present evidence, and the right to call witnesses and cross-examine.

Section 70 of the *Hospitals Act* also provides certain rights for patients and persons under observation at a psychiatric facility. Generally, a person will be able to communicate freely by mail, including reasonable access to letter writing materials. A person will be able to make unmonitored telephone calls except where this would be detrimental to the person or to others. A person will also be permitted to receive visitors. Written advice is to be provided to a person regarding letters, telephone use, visits, legal representation, file review, and review of capacity or competency declarations. A person in a facility is to be given assistance in understanding any document, in contacting a lawyer, and in applying for a review. In addition, the confidentiality of health information, relating to persons currently or formerly in a hospital, is largely protected at section 71. Subsection 70(7) provides that copies of section 70 and regulations respecting the rights of persons under observation or of patients shall be posted in a place within the facility where they can be seen by persons under observation or by patients.

7. Guiding principles

Commission discussions about the *Hospitals Act* were guided by a number of principles. The Commission considers it helpful to identify those principles which shaped Commission thought, discussions, and recommendations in this Report concerning reform of the *Hospitals Act*.[77]

One such principle is that the primary purpose of involuntary admission to a facility should be to facilitate access to psychiatric treatment and care. Unless otherwise noted, references to "treatment" in this Report mean psychiatric treatment and any related procedures. Where civil commitment is involved, psychiatric treatment is treatment required to improve the symptoms that cause a person to meet the criteria for involuntary admission.[78] These services become necessary when a person suffers from a mental disorder of such a severity that if untreated is likely to cause the person or others serious harm and to prevent the person from accessing treatment voluntarily. In many cases, a mental illness can prevent a person from accepting that he or she has an illness and therefore a need for treatment.[79] Once these symptoms are lessened to the point where a person no longer meets the involuntary admission standard, that person is to be discharged or can remain in the facility as a voluntary patient.

Psychiatric treatment can include the use of medications. It can involve electroconvulsive therapy (ECT).[80] Rehabilitative, educational, supportive, and other social and psychological therapies also can form part of psychiatric treatment. In relation to treatment, the focus in this Report is on those aspects which lessen symptoms, so that a person no longer qualifies for civil commitment. Although in some cases an aspect of social control is required, in order to protect a person or others from harm, this should not be the emphasis within the system. Related principles are that a delay in treatment often results in a denial of treatment, and that early treatment is critical to good prognosis.

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[77] In identifying and articulating these principles, the Commission has benefited from comments which Dr. J. Gray, of the B.C. Ministry of Health, made in relation to the Discussion Paper.

[78] Gray, Shone & Liddle, note 20, above, at 15-16.

[79] Note 20, above, at 3, 72.

[80] Electroconvulsive therapy is the treatment of mental disorder by producing unconsciousness and convulsions through the use of an electric current: F.C. Mish, ed., *Webster's Ninth New Collegiate Dictionary* (Markham, Ont.: Thomas Allen & Son, 1991) at 401-402.

Important qualifications must, however, be applied to principles identified above involving treatment. Psychiatric treatment and care must be provided in the least restrictive and intrusive manner possible. Moreover, as far as is reasonable, a patient must be involved in decisions concerning his or her treatment and care. The provision of involuntary services must also take place in accordance with the *Hospitals Act* and the *Charter*, with the *Charter* taking precedence in the event of a conflict.

In its Discussion Paper, the Commission suggested there are strongly held and often conflicting values involved in any discussion of mental health law. These differing perspectives were reflected during the course of Advisory Group discussions and were apparent in the comments received on the Discussion Paper. Canadian society places a high value on individual freedom, including self-determination, being able to take an active role, without interference, in deciding one's future. Part of self-determination involves choosing what, if any, medical treatment one is prepared to undergo. Individual freedom, however, is not absolute. For instance, limits may be placed on individual freedom when it would otherwise infringe the freedoms of other people. Individual freedom may conflict with another important value of Canadian society, that people should be free from danger at the hands of others. In the context of mental health law, it is also sometimes suggested there is a social responsibility to provide treatment to those individuals, who may not, as a result of mental illness, be able to recognize their need for treatment. In preparing this Final Report, the Commission, as with the Discussion Paper, has attempted to balance such values as the maintenance of individual freedom, the protection of the community from harm, and the facilitation of effective treatment for people with serious mental illness.

The next part of the Final Report considers the *Hospitals Act* in more detail.[81] In each section, particular issues are identified and discussed, followed by the Commission's recommendations for reform.

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[81] A number of other statutes may also affect people with mental illness in Nova Scotia. They include the *Incompetent Persons Act*, R.S.N.S. 1989, c. 218, the *Inebriates' Guardianship Act*, R.S.N.S. 1989, c. 227, and the *Adult Protection Act*, R.S.N.S. 1989, c. 2. These statutes did not, however, form part of the Reference provided to the Commission and apart from incidental mention, are beyond the scope of this Final Report.

III ISSUES FOR DISCUSSION

A. ADMISSION TO MENTAL HEALTH FACILITIES

Voluntary admissions

Under the *Hospitals Act* a person may be admitted to a facility as a person under observation or a patient either voluntarily or involuntarily. A voluntary patient is someone who remains in a facility with his or her consent and upon a physician's recommendation that the person requires the in-patient services provided by the facility.[82] The *Act* refers to such a person as an "informal patient." Most admissions to psychiatric facilities are of the voluntary type.[83] Canadian mental health legislation, similar to the approach in other countries, focuses almost exclusively on involuntary admission.[84] This is understandable, given that most admissions to a facility for psychiatric treatment are done in the same manner as admissions for other medical illnesses.[85] Consistent with this approach, the *Hospitals Act* contains few references to voluntary admission. The Commission understands that for the most part, concerns about the *Hospitals Act* seem to involve involuntary admission. As a result, this Final Report will focus on issues relating to involuntary admission.

It is possible that a person who does not have the capacity to provide or refuse consent to admission may seek to be admitted voluntarily to a facility. Although not resisting admission, some people may also not expressly consent to admission, but rather may simply acquiesce. In the interest of ensuring that people receive the care and treatment they require, the Commission takes the position that admission to facilities should be encouraged for those people who appear willing to seek care and treatment for mental illness. The Commission takes note that certain safeguards in the *Hospitals Act* are available for both voluntary and involuntary patients. Issues which may affect all patients, such as the capacity to accept or refuse treatment, and the review of decisions involving the nature of one's stay at a facility, will be considered below, in the context of involuntary patients.

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[82] *Hospitals Act*, note 50, above, s. 34(4).

[83] H.A. Kaiser, "Mental Disability Law" in J. Downie & T. Caulfield, eds., *Canadian Health Law and Policy* (Markham, Ont.: Butterworths, 1999) 217 at 241.

[84] Robertson, note 2, above, at 242.

[85] Gray, Shone & Liddle, note 20, above, at 20.

Involuntary admissions

1. Involuntary examination and assessment

Should the elements and duration of admission as a person under observation be changed?

Mental health legislation in most Canadian jurisdictions, including Nova Scotia, provides for a person's short-term involuntary admission to a psychiatric facility for the purpose of a medical examination and psychiatric assessment. The Nova Scotia *Hospitals Act* generally requires certificates from two physicians who have examined the person mentioned in the certificates. Where "compelling circumstances" exist, and a second physician is not available, it is possible to have someone admitted on the basis of one certificate.[86] In Nova Scotia, when admitted to a facility on a short-term, involuntary basis, an individual is referred to as a "person for observation."[87] Section 42 of the *Act* requires every person admitted for observation to be:

- examined by a physician and psychiatrist within 24 hours and three days, respectively;
- declared by a psychiatrist to have a psychiatric disorder and to be dangerous or not prior to the eighth day after admission; and
- released prior to the eighth day unless determined to be an involuntary patient, transferred or continuing in the facility as a voluntary patient.

Throughout Canada, the statutory criteria which must be satisfied before a physician can issue a certificate for examination and assessment are usually identical, or substantially similar, to the criteria used for admission as an involuntary patient. In some provinces, however, less rigorous criteria may be applied to admission for examination and assessment than for involuntary admission. For example, the legislation in Nova Scotia provides that at the preliminary stage of admission, as a person under observation, the standard is one of "reasonable and probable grounds" that the person is suffering from a psychiatric disorder and that the person is a danger to the safety of self or others. Subsequently, at the stage of involuntary admission as a patient, greater certainty is required. The psychiatrist must state that the person suffers from a psychiatric disorder and that the person is a danger to the safety of self or others.[88]

Subsection 34(2) of the *Hospitals Act* permits a person to be kept at a facility for a period of observation of up to seven days. Other provinces have specified periods that can range from

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[86] *Hospitals Act*, note 50, above, s. 36(9).

[87] Note 50, above, s. 34(2).

[88] Note 50, above, ss. 36(2), 42(2).

24 hours (Alberta) to 15 days (Newfoundland), with most Canadian jurisdictions prescribing a maximum of 24 to 72 hours confinement.[89]

In the Discussion Paper, the Commission expressed the view that the test to admit persons for observation need not be as stringent as the test for involuntary admission as a patient. In the event of someone who shows signs of having a mental illness and being a danger to self or to others, more of an emphasis, it was suggested, should be placed on getting that person to the safety of a facility, where an assessment could be completed. With the passage of time after the original admission, more information would become available about the nature of a person's mental health. Given the availability of additional details, as well as the fact that admission as an involuntary patient would involve significant and perhaps lengthy infringement on personal freedom, the Commission took the position that the standard for involuntary admission should be higher. To accomplish these aims, the Commission suggested that the current wording of the *Hospitals Act*, which at subsection 36(2) requires "reasonable and probable grounds" for admission as a person under observation, but a higher standard for admission as an involuntary patient, should be retained.

The Commission took note in the Discussion Paper of the need to have assessments completed quickly, to lessen infringements on personal freedom, as well as the need for assessments to be based on sufficient information. If psychiatrists do not have adequate time during which to interview and observe a person, the Commission suggested, then they may be inclined to err on the side of caution, namely by having a person involuntarily admitted as a patient. To best balance the needs for a speedy and thorough assessment, the Commission suggested, it should be completed as quickly as possible, in compliance with professional standards. The suggested standard time period for completion of an assessment was 24 hours, with a possibility for an additional 48 hours in exceptional cases.

The Discussion Paper suggestions on this issue resulted in a variety of responses from commentators. A number of commentators expressed agreement with the suggestion for the continued use of "reasonable and probable grounds" for admission as a person under observation, but preferred a higher standard for involuntary admission. Some commentators added that the term "reasonable and probable grounds," the meaning of which is largely to be found in case law, should be defined in the legislation.

Many of the commentators agreed that speeding up the observation process was a good idea, but that 24 hours for completion of an examination was not long enough. It was suggested that given limited resources at psychiatric facilities, the reality that some people are admitted on statutory holidays or on weekends, the need in many situations for more than 24 hours to evaluate certain people, as well as the waiting period that sometimes arises concerning the receipt of results from laboratories, often a 24 hour standard would be too short. It was also suggested that with a shorter standard in place, more people would be admitted as patients involuntarily. Not all commentators agreed, however, that 24 hours would be inadequate for completion of an examination. It was also pointed out in the comments received that the Discussion Paper was not consistent concerning its use of the terms "examination" and "assessment."

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[89] Gray, Shone & Liddle, note 20, above, at 160.

The Commission is of the view that the term "reasonable and probable grounds" is a term of art, which is used in the law in a number of ways. It is a flexible term, which takes its meaning from the specific facts of a situation. Given the adaptable and context-specific nature of this term's meaning, the Commission does not consider it helpful to define it in a mental health statute. Rather, if guidance is required about this term's meaning, this can be found in the case law, which will provide the relevant details of particular situations in which the term has been interpreted. The Commission affirms its Discussion Paper suggestion and recommends that the current wording of the *Hospitals Act*, which at subsection 36(2) requires "reasonable and probable grounds" for admission as a person under observation, but a higher standard for admission as an involuntary patient, should be retained.

The Commission took note of the concern among a number of commentators, and in particular medical professionals, that the 24 hour period, suggested in the Discussion Paper for completion of an assessment, was not long enough. The Commission wishes to clarify that it had in mind in this context the time period for completion of an examination and not an assessment. In an ideal world, 24 hours would be a preferable standard, but this would not always be realistic. The Commission recommends instead that a period not to exceed 48 hours for completion of an examination by a psychiatrist would be a better standard, one which strikes a balance between minimizing infringement on personal freedom and the need to conduct a complete examination based on sufficient information. It would still represent a considerable improvement in relation to the current 72 hour standard. Although recommending that a psychiatric examination be completed within 48 hours, the Commission is not advocating that an examination should necessarily take that amount of time. Rather, in general an examination should be completed as quickly as possible, in compliance with professional standards.

The Commission recommends:

- The current wording of the *Hospitals Act*, which at subsection 36(2) requires "reasonable and probable grounds" for admission as a person under observation, but a higher standard for admission as an involuntary patient, should be retained.
- The standard time period for completion of a psychiatric examination should not exceed 48 hours.
- An examination should be completed as quickly as possible, in compliance with professional standards.

2. Pursuant to medical certificates

Who should have authority to admit persons for observation to mental health facilities?

a) Physicians

Under Canadian mental health law, the use of medical certificates is the most common method to secure a person's involuntary admission for purposes of examination and assessment.[90] In Nova Scotia, section 36 of the *Hospitals Act* provides that two physicians, each of whom must have examined a person, may complete medical certificates in order to have the person admitted involuntarily to a facility for observation. All other Canadian jurisdictions ordinarily require one medical certificate in most situations for a person to be admitted for observation.

In Nova Scotia, the medical certificates must state that the physician has reasonable and probable grounds to believe the person is suffering from a psychiatric disorder and should be admitted to a facility because he or she needs in-patient services and requires care that cannot be adequately provided outside the facility, because he or she is a danger to his or her own safety or the safety of others. Following admission as a person under observation, if the person is to continue as an involuntary patient, prior to the eighth day after admission a psychiatrist must complete a declaration of involuntary admission stating that the person suffers from a psychiatric disorder and that the person is a danger to the safety of self or others.

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[90] Kaiser, note 83, above, at 242.

b) Tribunal

A tribunal is a body or person exercising a statutory decision-making power outside the regular court system.[91] A tribunal could be set up to decide whether or not a person should be admitted to a facility for the purposes of a psychiatric examination and assessment. New Brunswick is the only province or territory with a tribunal which makes decisions relating to the admission of persons to facilities under mental health legislation. It is important to note that the New Brunswick tribunal determines whether or not a person, who was brought to a facility for observation, and who has already been examined and assessed by a psychiatrist, will be admitted as an involuntary patient. Even in New Brunswick, a certificate from one physician is needed in order to justify a person's admission for observation.

As another means of ensuring that the admission for observation process is conducted fairly, rather than using a multi-member tribunal, some people prefer the use of a one-person decision-maker, a "judicial arbiter," as this could provide greater speed and flexibility. The judicial arbiter, who would be either a Provincial Court judge or a justice of the peace, would hear medical evidence and decide about a person's admissibility to a facility.

c) Courts

Under s. 37 of the *Hospitals Act,* any person may give information to the Provincial Court of his or her belief, on reasonable and probable grounds, of another person having a psychiatric disorder and being dangerous. Following the receipt of such information, the judge may direct an examination or order the apprehension of the person identified, for the purpose of determining if the person fits the criteria for admission as a person under observation.

Section 37 does not empower a court to order a person's admission to a facility, either for observation or as an involuntary patient. Ultimately, physicians make these decisions. Nonetheless, one might still contemplate the possibility of a court having the power to order a person to be admitted to a facility for observation.[92] In Quebec, the only Canadian jurisdiction where courts participate in the admission process, a court is used to confirm whether or not someone is to be admitted as a patient to a facility.

The Law Reform Commission of Saskatchewan recommended against having committal decisions being routinely made by the courts. It cited a number of factors, including the judiciary's lack of training in psychology and psychiatry, the need for deference to medical expertise, and the inevitable delay involved in court proceedings.[93]

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[91] D.A. Dukelow & B. Nuse, *The Dictionary of Canadian Law* (Scarborough: Carswell, 1991) at 1103.

[92] Gray, Shone & Liddle, note 20, above, at 163.

d) Analysis of the admission for observation mechanisms

In the Discussion Paper, this Commission was of the view that the current admission process, which relies on medical certificates provided by physicians, should be continued. The Commission was concerned that to involve a tribunal at the stage of admitting people for observation could make the process unnecessarily long, complex, and adversarial. Arranging for a tribunal to meet within a sufficiently short time, it was suggested, could prove difficult in some rural areas. The Commission was also not in favour of adopting a judicial arbiter system. Even if education in medical issues was provided to justices of the peace, it was suggested that a psychiatrist's opinion would still largely determine the matter of admission. Accessibility to a judicial arbiter could be difficult in rural areas. Given their significant individual workloads, it was suggested, physicians may not have time to attempt to contact a judicial arbiter and convey the facts of the situation at hand. Although courts are experienced in protecting and balancing rights, the Commission was not of the view that courts should constitute the primary means of admitting people to facilities. The congested nature of the court system, the Commission suggested, is not consistent with the need in many cases for a quick determination of a person's admissibility. Moreover, courts would still have to rely on evidence provided by psychiatrists or physicians.

From the Commission's perspective, the most efficient and thorough process for making a decision about involuntary admission for the purpose of observation, a decision dependent on medical knowledge and experience, was to continue to entrust it to those people qualified to practice medicine. The Commission therefore suggested that the *Hospitals Act* should continue to allow for the involuntary admission of a person for observation on the basis of two medical certificates provided by physicians, or one certificate in compelling circumstances.

The Commission understood that admission to a facility for purposes of an examination by means of a judicial order occurs infrequently. Nonetheless, the Commission considered this admission route to be a useful one, albeit secondary, which should be retained. Among its reasons, the Commission suggested that the judicial order procedure allows for greater flexibility in the admission process. It allows someone concerned about another person's mental condition to apply for examination of that other person, in situations where the other person would not willingly undergo a psychiatric examination. This route of admission is a balanced one, it was suggested, as court proceedings allow for the person who would be the subject of a warrant for examination to express his or her views. The Commission suggested that the possibility of detention and examination by a judicial order under the *Hospitals Act*, though not the primary route for admission, should be retained.

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[93] Law Reform Commission of Saskatchewan, *Proposals for a Compulsory Mental Health Care Act* (Saskatoon: The Commission, 1985) at 19. Nevertheless, that Commission was of the opinion there was still a role for courts. The Saskatchewan Commission suggested that court approval should be required to extend a committal period. In that Commission's opinion, such an approach would minimize court involvement, but would still provide adequate protection for the rights of involuntary patients [p. 20].

The Discussion Paper suggestions resulted in a wide range of comments. One commentator, who was in favour of the Commission suggestions, was of the view that tribunals or courts, unless made up of mental health experts, would not provide any better protection than a physician against wrongful admission after examination. It was further suggested that tribunals or courts can delay treatment and thus infringe on a person's right to be discharged from detention as soon as reasonable, thereby prolonging a person's potential suffering. That commentator also expressed support for the continued role of general practitioners in the admission process.

Among those comments received that were critical of the suggestions, one suggested that the current system depends too much on general medical practitioners, who are not only overworked, but who have inadequate knowledge of psychiatry. Other commentators suggested that the Commission's rejection of the tribunal concept seemed to be based upon a concern for expediency and saving money, as opposed to ensuring proper procedures were in place. It was also suggested that the use of a tribunal system would free physicians to tend to the needs of mental health consumers, rather than having to make decisions that affect people's freedom.

The majority of the Commission remains of the view that for admission as a person under observation, where an examination is to take place within 48 hours, the requirement for two medical certificates in most cases should be retained. In addition to the reasons set out in the Discussion Paper, the majority agrees, the two-certificate requirement provides greater assurance that people are only being admitted to facilities when they satisfy the relevant criteria. In many cases, medical certificates required for involuntary admission are completed by general practitioners, who are not involved with mental health issues on a frequent basis, and who may not be comfortable with making an admission decision on their own. As a result of the two-certificate requirement, a physician's decision to admit for observation will have to be validated by the concurring opinion of another medical practitioner.

Having said this, the Commission also takes note that Nova Scotia is the only jurisdiction in Canada which requires two medical certificates for admission as a person under observation. The Commission agrees that only one certificate could be appropriate, in those cases where the physicians involved would be able to justify why only one certificate was used. There may be certain situations where factors such as an emergency or a lack of available physicians would make it inadvisable to insist upon two medical certificates. The current statute, however, at subsection 35(9), requires both "compelling circumstances" and the lack of a second available physician in order to justify dispensing with the two-certificate requirement. The Commission considers this provision, as currently phrased, to be too restrictive.

The Commission recommends that the *Hospitals Act* should continue to allow for the involuntary admission of a person for observation on the basis of two medical certificates provided by physicians. Admission for observation should also be possible based upon one certificate where the attending physician is able to justify why only one certificate was used.

The Commission is still not in favor of adopting a tribunal in Nova Scotia. Data has yet to be compiled about the effectiveness of the New Brunswick tribunal. Given a lack of medical expertise among tribunal members, the tribunal might simply serve as a rubber stamp to the recommendations of physicians. The Commission is also reluctant to support the establishment of another bureaucratic structure.

For those reasons provided in the Discussion Paper, namely of flexibility and balance, the Commission recommends that the possibility of detention and examination by authority of a judicial order should be retained. Nonetheless, the Commission has not changed its view, expressed in the Discussion Paper, that given the congested nature of the courts, as well as a need to rely upon medical evidence, courts should not be used to determine whether or not a person is to be involuntarily admitted to a facility as a patient.

The majority of the Commission recommends:

- The *Hospitals Act* should continue to allow for the involuntary admission of a person for observation on the basis of two medical certificates provided by physicians. Admission for observation should also be possible based upon one certificate where the attending physician is able to justify why only one certificate was used.

The Commission recommends:

- The possibility of detention and examination by authority of a judicial order should be retained.

3. Criteria

a) Definition of "mental disorder"

How should mental disorder be defined?

One of the criteria for involuntary admission under Canadian mental health legislation is a diagnosis of mental disorder. An equivalent term is defined in each province and territory except Quebec. Nova Scotia's *Hospitals Act* uses the term "psychiatric disorder," which it defines at s. 2(q) as "any disease or disability of the mind [including] alcoholism and drug addiction." Newfoundland and Ontario share a definition of "mental disorder" which is similar to that of Nova Scotia: "any disease or disability of the mind."[94] The Alberta, New Brunswick, the Northwest Territories, Nunavut, Prince Edward Island, Saskatchewan, and Yukon have adopted (some with minor changes) the Uniform Law Conference of Canada (ULCC)[95] definition of "mental disorder" which describes more specifically the level of mental impairment and its effects. The ULCC's *Uniform Mental Health Act* defines "mental disorder" as "a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life."[96]

In the Discussion Paper, the Commission was of the view that the more general, less technical term "mental disorder" should be used rather than "psychiatric disorder." The Commission took the position that the ULCC definition of "mental disorder" is appropriate, being specific enough to provide guidance, but also general enough to allow flexibility in application. The Commission acknowledged there are differing viewpoints on the merits of specifying particular conditions as part of a definition. For instance, the Commission thought that alcohol or drug addiction should not be included, even though this is treated as a psychiatric illness in the *Diagnostic and Statistical Manual*,[97] used by mental health care professionals. The Commission sought comments on what, if any, conditions should be specifically mentioned in the definition.

A number of commentators expressed support for the use of the term "mental disorder." Among the supportive comments received, however, there was little consensus about the specifics of this definition. For instance, one commentator suggested that the Commission's proposed definition was not realistic, as it implies clear definitions are possible in a field that lacks definite boundaries. The definition should be broadened, this commentator suggested, in order to allow room for clinical judgment on the part of psychiatrists. The counter position expressed was that a more detailed definition can provide greater guidance to health care professionals, and that the Nova Scotia definition is currently too vague.

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[94] Newfoundland, *Mental Health Act*, R.S.N. 1990, c. M-9, s. 2(g); Ontario, *Mental Health Act*, R.S.O. 1990, c. M-7, s. 1.

[95] The Uniform Law Conference of Canada (ULCC) is an independent organization which promotes the uniformity of legislation in Canada concerning subjects for which uniformity may be found possible and advantageous.

[96] Uniform Law Conference of Canada, *Proceedings of the Sixty-ninth Annual Meeting*, Appendix F (Victoria, B.C., 1987) at 262.

[97] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV* (Washington, D.C.: The Association, 1994).

One commentator suggested that the proposed definition was too restrictive; using as it does the term "grossly," it may exclude certain people who are in need of involuntary admission. This commentator suggested that the definition would be strengthened by a reference to a need for psychiatric treatment. This, it was suggested, would confine the potentially affected group to the narrowest reasonably possible, would reinforce the purpose of involuntary admission as being treatment and not social control, and would preclude the need for additional references to conditions relating to alcohol and drugs. Using different language, but reaching a similar conclusion, another commentator suggested that regardless of the term used, it was critical for admissions to psychiatric facilities to be restricted to those members of the population who could benefit from mental health interventions.

Some commentators did not consider it appropriate for conditions such as Alzheimer Disease[98] to be included within the definition. Concern was expressed by some about the inclusion of alcoholism and drug addiction, while others suggested that alcohol and drug dependency should indeed be included, as these conditions can involve psychiatric complications.

Further to a number of comments received about the Discussion Paper, the Commission devoted considerable discussion to the question whether or not the definition of mental disorder (and therefore the criteria for involuntary admission) should include a requirement for the disorder's treatability. This issue is particularly relevant in the context of personality disorders. These have been defined as long-standing abnormalities of an individual's thinking, feeling, and behaving that create serious problems for the individual, society, or both. An example of a type of personality disorder is antisocial personality disorder, or psychopathy. Unlike people with many other types of mental disorders, individuals with antisocial personality disorder are not impaired in their ability to make rational choices. Moreover, personality disorders in general are seldom improved through treatment.[99]

Difficult questions can arise concerning people whose personality disorders have resulted in violent or dangerous behavior. To detain such a person in a mental health facility could mean that for this person, the facility is a mere detention centre. Moreover, the presence of dangerous and uncooperative people could hinder the treatment of other patients. Depriving a person of his or her liberty, by having that person civilly committed, is an extraordinary measure which can only take place in accordance with the statutory criteria. If a person with a personality disorder did not satisfy the involuntary admission criteria, such as whatever standards were set out for the immediacy of harm, then that person could not be retained in a facility. Upon returning to the community, that individual, like any other person, could only be subject to criminal law sanctions if he or she committed a criminal offence. If, however, that person has shown a propensity for violent or dangerous behavior, then society or that person could be placed at risk if that person returns to the community.

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[98] Alzheimer Disease is the leading cause of dementia, a set of symptoms including loss of memory, judgment and reasoning, as well as changes in mood and behaviour. Alzheimer Disease gradually destroys vital nerve cells in the brain: Alzheimer Society of Canada, "What is Alzheimer Disease?" online: Alzheimer Society of Canada Web site <http://www.alzheimer.ca/english/disease/whatisit-intro.htm> (last modified: September 2001).

[99] Gray, Shone & Liddle, note 20, above, at 86-97, 111-113.

The Commission is of the view that ideally, with sufficient resources, facilities would be established for the care of people who have a mental disorder which is not conducive to treatment at current mental health facilities, who have an established tendency towards violent or dangerous behavior, and who have not committed any new offences which would justify the involvement of the criminal justice system. Given, however, the realities of current resources, the Commission considers it unlikely that such a new type of care centre will be established in the near future. As a result, the Commission is reluctant to exclude people with personality disorders from mental health facilities, through the use of admission criteria requiring the treatability of a disorder. With advancements in medical knowledge, it may also arise that personality disorders become increasingly susceptible to treatment.

The lack of consensus among commentators illustrates the difficulty of attempting a definition of mental disorder that is acceptable to all. Given the lack of consensus, the Commission does not think it helpful to amend its proposed definition, either to include or exclude particular conditions. Rather, the Commission prefers a more general definition, which provides guidance by identifying the main possible symptoms of mental disorder, as well as the consequences of these symptoms, but which is adaptable to particular circumstances.

The Commission affirms its suggestions from the Discussion Paper on this issue. Therefore, the Commission recommends that the term "mental disorder" should be used rather than "psychiatric disorder." "Mental disorder" should be defined as a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life.

The Commission recommends:

- The term "mental disorder" should be used rather than "psychiatric disorder."
- "Mental disorder" should be defined as a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life.

b) Dangerousness

Should a person's involuntary admission continue to be based on the concept of dangerousness?

In Canadian mental health law, the second criterion for civil commitment tends to be based on the concept of "dangerousness," which implies that an act of violence or harm will otherwise occur.[100] One way in which the concept of dangerousness is incorporated into mental health legislation is by means of the word "safety." Subsection 36(2) of the *Hospitals Act* establishes a typical "safety test" as the minimal ground for a person's involuntary admission. In part, it insists that a person "requires care that cannot be adequately provided outside the facility because he is a danger to his [or her] own safety or the safety of others." A similar approach has been adopted in Prince Edward Island and Newfoundland.[101] The Prince Edward Island Court of Appeal has stated that the word "safety" goes beyond mere protection from infliction of physical injury and "includes such things as the alleviation of distressing physical, mental or psychiatric symptoms as well as the provision of creature comfort in appropriately congenial physical surroundings."[102]

Rather than using "safety," the British Columbia *Mental Health Act* refers to "protection." Involuntary admission is permitted if the person "requires care, supervision and control in a Provincial mental health facility for the person's own protection or for the protection of others."[103]

In Alberta's legislation, the concept of dangerousness takes the form of a requirement that the person suffering from a mental disorder is "in a condition presenting or likely to present a danger to himself or others."[104] "Danger" in the Alberta statute has been interpreted to mean a serious risk of physical harm, rather than mental or emotional harm.[105]

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[100] J. Arboleda-Flórez & M. Copithorne, *Mental Health Law and Practice* (Toronto: Carswell, 1994) at 1-50.

[101] Newfoundland statute, note 94, above, s. 5; Prince Edward Island, *Mental Health Act*, S.P.E.I. 1994, c. 39, s. 6. Under the Newfoundland statute, the interest of "safety to property" is also a criterion for civil commitment.

[102] *Reference re Mental Health Act* (1984), 5 D.L.R. (4th) 577 at 589.

[103] British Columbia, *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 22.

[104] Alberta, *Mental Health Act*, S.A. 1988, c. M-13.1, s. 6.

[105] *M.* v. *Alberta* (1985), 63 A.R. 14 at 29 (Q.B.).

Ontario's *Mental Health Act*, an amended version of which came into force in 2000,[106] provides that after examination, a person must be admitted as an involuntary patient if suffering from a mental disorder of a nature or quality that, unless the person remains in the custody of the psychiatric facility, will likely result in:

(1) serious bodily harm to the person,
(2) serious bodily harm to another person, or
(3) serious physical impairment of the person.[107]

The person must also not be considered suitable for admission or continuation as a voluntary patient.

What is meant by "serious physical impairment" is likely to be explained by reference to case law which considered an earlier standard, "imminent and serious physical impairment." The term "imminent and serious physical impairment" was not intended to relate to persons who have no interest in self-care, but only to situations where a person's life or physical integrity is at stake as a result of his or her mental illness.[108] For example, the court noted in *Foran* v. *O'Doherty* that a history of failing to take medication and being led into undesirable activities, substance abuse, a failure to manage one's money or a slovenly lifestyle will not authorize a person's detention where there is no evidence that the person is likely to suffer serious physical impairment as a result of that behaviour.[109] By contrast, in *B(L) v. O'Doherty*,[110] in choosing to uphold the continuation of an involuntary patient's stay at a facility, the court accepted the probability that upon discharge, the patient would revert to poor eating habits, which would likely result in a stroke.

As shown by Ontario's use of "serious physical impairment," some committal criteria anticipate that harm to a person could take the form of a series of acts or omissions, occurring over a length of time, rather than as part of a single event. Another example is the term

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[106] For the changes, see *Brian's Law (Mental Health Legislative Reform, 2000)*, S.O. 2000, c. 9.

[107] Ontario statute, note 94, above, s. 20(5).

[108] D. Schell, S. Malcolmson & P. Klassen, "The Hospitalized Psychiatric Patient: Clinical and Legal Aspects of Care" in H. Bloom & M. Bay, eds., *A Practical Guide to Mental Health, Capacity and Consent Law of Ontario* (Toronto: Carswell, 1996) 121 at 138.

[109] (November 7, 1986), docket no. 1981/86 Thunder Bay (Ont. Dist. Ct.), cited in Schell et al., note 108, above, at 138-139.

[110] (April 14, 1986), docket no. 1226/86 Thunder Bay (Ont. Dist. Ct.), referred to in Robertson, note 2, above, at 393. The factor "imminent and serious physical impairment of the person" is also found in the legislation of the Northwest Territories (R.S.N.W.T. 1988, c. M-10, s. 8), which has been adopted in Nunavut. According to the Yukon *Mental Health Act*, (S.Y. 1989-90, c. 28, s. 5), the requirement is that of "impending serious mental or physical impairment."

"substantial mental or physical deterioration," which is also part of the Ontario statute, in the form of committal criteria applicable to people who have experienced at least one instance of successfully treated mental disorder. The latter standard might be applied to ensure that people who have already been involuntary patients, and who have responded to treatment in the past, will not have to relapse fully, to the extent of mental disorder they previously experienced, before they meet involuntary admission criteria.[111]

Not all mental health statutes limit the concept of harm to physical harm. In fact, although not all referring explicitly to "psychological harm," the majority of Canadian jurisdictions allow for involuntary admission when serious non-physical harms are likely to occur unless a person is admitted and treated. Psychological harm is used specifically in two jurisdictions, New Brunswick and Yukon. The New Brunswick standard refers to "a substantial risk of imminent physical or psychological harm to a person or others," while the Yukon standard refers to "the person's impending serious mental or physical impairment."[112]

In terms of the nature of harm that civil commitment is designed to prevent, the majority of the Commission expressed the view in the Discussion Paper that bodily harm alone would be too narrow a standard. Some conditions, such as schizophrenia,[113] if left unchecked, though they do not involve actual physical harm to a person, can progressively worsen, with little or no possibility of redressing the deterioration in a person's mental functioning. The majority of the Commission therefore suggested that the Nova Scotia legislation should allow for the involuntary admission of someone with a mental disorder not only when bodily harm is likely, but also when there is a likelihood of psychological harm to self.

The majority of the Commission also considered it important for Nova Scotia law to take into account the possibility that harm could occur, not only through an immediate, single act, but also over a longer period and as part of a series of acts. As a result, the majority of the Commission suggested in the Discussion Paper that the statute should include a provision relating to a person's "imminent and serious impairment" as part of the criteria for involuntary admission.

In the Discussion Paper, the Commission noted that the state's power to involuntarily hospitalize involves a significant infringement on personal freedom. It would be extending such infringement too far, it was suggested, to allow for the hospitalization of someone simply because he or she is dealing with property in an atypical or reckless fashion. The Commission also pointed out that for those people truly incapable of taking care of their property or finances, guardianship orders are available.[114] As a result, the Commission suggested in the Discussion Paper that neither harm to property nor finances should be available as a ground for a person's involuntary admission to a facility.

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[111] Ontario statute, note 94, above, s. 20(1.1).

[112] New Brunswick, *Mental Health Act*, R.S.N.B. 1973, c. M-10, s. 8(4); Yukon statute, note 110, above, s. 5.

[113] Schizophrenia is a brain disorder, the symptoms of which include disorganized thinking, delusions, hallucinations, and changes in emotions and behaviour: Schizophrenia Society of Canada, "What Exactly is Schizophrenia?" online: Schizophrenia Society of Canada Web site <http://www.schizophrenia.ca/info.html> (date accessed: 3 December 2001).

To help diminish the potential misuse of civil commitment, the Commission took the position that the *Hospitals Act* should make clear the need for a causal relationship between a mental disorder and a danger to self or others. This is necessary, it was suggested, to avoid the civil commitment of either people who have mental illness, but who do not pose a danger, or of dangerous people without mental illness.

The section in the Discussion Paper on dangerousness and related issues generated a considerable amount of commentary. As with much of the commentary involving the Discussion Paper, the comments reflected a wide range of often differing perspectives. A number of commentators expressed support for the Commission's suggestions, and in particular the attempt to broaden the involuntary admission criteria beyond a risk of bodily harm to self or others. Many commentators, however, expressed concern about the suggestion to expand involuntary admission criteria to include psychological harm to self. These concerns took different forms. Some commentators suggested that the term "psychological harm" was ambiguous and would be difficult to use in a practical sense. It was suggested this would lead to different interpretations and usage. These commentators also tended to agree, however, that the current *Act* is restrictive to the point that some patients in need of psychiatric care are not receiving it. Other commentators, though similarly concerned about the suggestion concerning psychological harm, took a different approach. They suggested that the Commission's proposal would vastly increase the range of behavior and emotional states that could be subject to involuntary examination and possible treatment. As a result, they suggested, the Commission's proposal would jeopardize the liberty and autonomy of a much wider range of citizens and would create a need to increase the population within mental health facilities. In other words, they suggested, there should be a de-emphasis on involuntary treatment.

It was also suggested by some commentators that the vagueness of the term "psychological harm" could invite misuse of civil commitment. They suggested that increased demands would be placed on in-patient mental health services to accommodate, in particular, the fears of family and friends of individuals with serious mental disorders. Although involuntary admission was justified in order to save a person's life or the life of someone else, it was suggested, nothing was to be gained by forcibly detaining a person at risk given the potential to cause psychological harm to self. It was added that involuntary admission can do harm to a person's stability, sense of well-being, and ability to reintegrate into the community.

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[114] A guardian is an individual with the right and duty of protecting the person, property, or rights of someone who is not mentally capable or is otherwise unable to manage his or her own affairs: R. Bird, *Osborn's Concise Law Dictionary*, 7th ed. (London: Sweet & Maxwell, 1983) at 160.

A number of commentators suggested that harm to property or finances should not be removed as a ground for involuntary admission. It was suggested that in certain situations, people with mental illness can inflict long term suffering on their families and on themselves through destruction or loss of property. For example, it was possible for people with mental illness to spend large sums of money, leaving either themselves or their families in the state of destitution.

Further to comments received and following additional discussions, the Commission sought an admission criterion which was wider in scope than danger, yet which did not suffer from the ambiguity of "psychological harm." The Commission took note of the term "serious harm," which in the mental health statute context has been referred to approvingly by a number of Canadian courts, and in particular, in the context of the *Charter*.

Thwaites v. *Health Sciences Centre Psychiatric Facility* [115] involved a constitutional challenge to the Manitoba mental health statute's compulsory detention provisions. The challenge was brought by T, a former involuntary patient. By the time of the application, T was no longer in a facility, and the provisions in issue had been repealed and replaced. The essence of T's argument was that the criteria for compulsory admission had not been statutorily set out when he had entered the facility. As a result, T argued, his right under s. 9 of the *Charter* not to be arbitrarily detained or imprisoned had been violated. The Manitoba Court of Appeal held that as the former statute did not narrowly define the persons to whom the admission provisions could properly be applied, nor did it specify the conditions under which a person could be detained, the compulsory admission provisions were clearly arbitrary and infringed section 9 of the *Charter*. They were not saved by a section 1 reasonable limits test.

By contrast, the court commented favourably on the then-new Manitoba provisions, which incorporated the tests of "serious harm" and "substantial mental or physical deterioration" into the compulsory admission process. The court suggested, "they will ensure that those persons suffering from a mental disorder and likely to cause serious harm to themselves or others or to suffer substantial mental or physical deterioration will have available to them the treatment they require, even as involuntary patients."[116] The court also seemed to accept that the new criteria achieved a proper balance between individual liberty and community interests.

Bobbie v. *Health Sciences Centre*,[117] which was heard after the Manitoba statute had been amended, involved facts similar to those at issue in *Thwaites*. In *Bobbie*, the Manitoba Court of Queen's Bench accepted that the Manitoba involuntary admission standard, which involved a requirement for a mental disorder and specific objective criteria, allowed for the balancing of individual rights with the protection of society as a whole. The court also indicated that Manitoba's standard, a form of the dangerousness test for involuntary admission, had been accepted as appropriate by other legislatures, as well as by law reform commissions and other knowledgeable groups.[118] The Manitoba provisions were held not to violate either section 7 or 9 of the *Charter*.

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[115] [1988] 3 W.W.R. 217 (Man. C.A.).

[116] Note 115, above, at 231.

[117] (1988), [1989] 2 W.W.R. 153 (Man. Q.B.).

At issue in *McCorkell* v. *Riverview Hospital*[119] was the validity under the *Charter* of the involuntary committal and detention provisions found in the British Columbia *Mental Health Act*. Section 7 of the *Charter* provides for the right to life, liberty and security of the person. The operative word in the B.C. statute was "protection," either of a mentally ill person or of others. During the course of rejecting the applicant's argument, the B.C. Supreme Court referred to the wide interpretation that had been given to the Manitoba standard of "serious harm." The court indicated that the "serious harm" standard could include "harms that relate to the social, family, vocational or financial life of the patient as well as to the patient's physical condition." The court also rejected the applicant's argument that "dangerousness" was the only possible criterion permissible under the *Charter*.

The majority of the Commission agrees with the appropriateness of the term "serious harm" as part of the involuntary admission criteria. "Serious harm" is a term which is easily understandable, flexible in its application, and acceptable under the *Charter*. The majority is also of the view that "serious harm" would take into account not only events about to happen immediately, but in addition, consequences which occur more gradually. As a result, use of the "serious harm" criterion would preclude the need for a deterioration or impairment standard. The medical profession and the courts would be entrusted to determine the contents of "serious harm." Consistent with the concerns of certain commentators, summarized in the preceding pages, concerning expansion of the informal admission criteria, one Commissioner advocates the continued use of the present statutory concept, "danger to his [or her] own safety or the safety of others."

The majority of the Commission also agrees that harm to property or finances should not be specified as part of an involuntary admission standard. The majority takes the position that otherwise the potential for abuse, on the part of unscrupulous friends or relatives, is too strong. Another Commissioner concurs with the reasoning of certain commentators, summarized above, and takes the position that harm to property or finances could ultimately prove more serious than physical harm.

The majority of the Commission therefore recommends that the Nova Scotia legislation should allow for the involuntary admission of someone with a mental disorder when "serious harm" is likely to self or others. Neither harm to property nor finances should be specified as a ground for a person's involuntary admission to a facility.

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[118] Note 117, above, at 160.

[119] [1993] 8 W.W.R. 169 (B.C.S.C.).

The Commission also affirms its suggestion from the Discussion Paper that the *Hospitals Act* should make clear the need for a causal relationship between a mental disorder and, depending on the standard that is chosen, serious harm or danger to self or others.

The majority of the Commission recommends:

- The Nova Scotia legislation should allow for the involuntary admission of someone with a mental disorder when "serious harm" is likely to self or others.
- Neither harm to property nor finances should be specified as a ground for a person's involuntary admission to a facility.

The Commission recommends:

- The *Hospitals Act* should make clear the need for a causal relationship between a mental disorder and, depending on the standard that is chosen, serious harm or danger to self or others.

4. Peace officers

Should the current procedure for the involvement of peace officers be revised?

The *Hospitals Act* provides for the involvement of peace officers in the civil commitment process in a number of ways. Following receipt of duly completed medical certificates or a warrant, a peace officer is required to apprehend the identified person so that an examination can be completed. Subsection 38(1) also permits a peace officer who reasonably believes that a person is mentally disordered, and that the person is (a) dangerous or (b) is committing or about to commit an indictable offence, to take the person to an appropriate place for examination. Clause 38(1)(b) is unique to Nova Scotia, among Canadian jurisdictions.[120]

Subsection 39(3) provides in part that when a person has been brought by a peace officer to a facility for examination, and the person is not admitted, he or she shall be returned to the place where apprehended. That subsection does not indicate, though, whether or not peace officers are expected to return the person. Section 46 of the *Hospitals Act* authorizes peace officers to return to a psychiatric facility those persons who have been involuntarily admitted, yet who are absent from the facility without authorization.

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[120] Gray, Shone & Liddle, note 20, above, at 152.

Similar to section 38 of the *Hospitals Act*, all other provincial and territorial mental health statutes contain provisions which address a person's apprehension by peace officers for the purpose of a psychiatric assessment. It is also common, though not required by Nova Scotia law, for a peace officer to retain care and custody of an apprehended person until completion of the psychiatric examination, at which time the person is either admitted to the facility as a person under observation or released.[127] For example, in Ontario, if peace officers bring a person in custody to a facility, they must remain there and retain custody until the facility accepts custody of the person.[128] Similarly, Manitoba legislation provides that a peace officer's duty to retain custody of a person apprehended for the purpose of an involuntary examination or assessment does not apply "if the physician conducting the examination or assessment advises the peace officer that continuing custody is not required." The Manitoba statute also states that if a peace officer apprehends a person and brings that person to a facility for the purpose of an involuntary examination or assessment, but the person is not admitted, then the peace officer shall, if practicable, return the person to the place where he or she was apprehended, or to another appropriate place.[129]

The Discussion Paper suggested that clause 38(1)(a) of the Nova Scotia statute, which refers to a person who is dangerous to his or her own safety or the safety of others, is wide enough to take into account the situations covered by clause (b), which refers to indictable offences. Indictable offences, which are generally more serious criminal offences, can involve harm to either persons or property. The Commission took the position there should be no confusion of the criminal law and the law of civil committal. From the Commission's perspective, either a person should be arrested and dealt with by the courts for an alleged criminal offence, or should be brought to a facility for a psychiatric assessment if he or she meets the standard of appearing to be mentally disordered and dangerous. As a result, the Discussion Paper suggested, clause 38(1)(b), which provides for the apprehension of a disordered person "committing or about to commit an indictable offence," was not necessary and should be removed.

The Commission was also of the view that once a peace officer has apprehended and brought a person to a facility for an examination, it should not be necessary for the peace officer to remain, unless the safety of the apprehended person or other people might be endangered.[130] It would make better sense, it was suggested, to free the peace officer to tend to his or her other duties. This could be especially important in rural areas of the province, where police detachments can be small and patrol areas large. Depending on the workload at a facility, it might be a number of hours before an examination could be completed. The Commission therefore suggested in the Discussion Paper that peace officers should be permitted to leave a facility during the time that the person apprehended and brought in by the peace officers is being examined. To avoid misunderstandings, it was suggested, consent for peace officers to depart a facility should be in writing.

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[127] The Commission understands that peace officers in Nova Scotia, though not required to do so by statute, tend to remain at a facility while an examination is being completed.

[128] Ontario, Ministry of Health and Long-Term Care, *Rights and Responsibilities: Mental Health and the Law* (Ontario: Queen's Printer, 2001) at 15.

[129] Manitoba, *Mental Health Act*, S.M. 1998, c. 36, C.C.S.M. c. M110, s. 15.

If the result of an examination is that a person meets the standard for involuntary admission, then peace officers will not be required to return to a facility. If a person does not meet the standard, then another issue which arises is whether or not peace officers should be informed. Rather than arresting a person and charging that person with a criminal offence, peace officers, in compliance with section 38, may have brought the person directly to a facility for an examination. Although the person may not meet the criteria for admission, peace officers may still wish to charge the person with a breach of the criminal law. Peace officers might be reluctant to release a person into the custody of a facility if there was a chance that the person might walk free after the examination.

In the Discussion Paper, the majority of the Commission took the position that facility staff should have a duty to inform peace officers when the psychiatric examination of a person brought to a facility by peace officers is completed and the person is not admitted to the facility. The majority of the Commission acknowledged potential concerns about infringement of personal privacy and discrimination, but on balance, was of the view that in this context, the protection of public safety should take precedence over privacy rights. This would not, it was suggested, require facility staff to incriminate people, by informing peace officers of suspicions that a crime has taken place. Rather, the majority of the Commission suggested, peace officers would already have been involved in bringing the person to the facility, given an element of danger. The responsibility to decide whether or not a danger was sufficiently serious to require intervention of the criminal law would remain with peace officers. The majority of the Commission was of the view that without creating a duty to notify, the advantage of its suggestion about allowing police to depart a facility during an examination would be largely undermined.

The record of a patient's interactions with peace officers might have a bearing on the duration of the patient's stay in a facility. In the Discussion Paper, the Commission was of the view that a patient should have access to all relevant information concerning his or her admission to a facility. As a result, the Discussion Paper suggested, the *Hospitals Act* should require copies of relevant police reports to be included in a patient's psychiatric file.

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[130] In relation to this issue, the Discussion Paper also was inconsistent in its use of the terms examination and assessment. The Commission had in mind a person being brought to a facility for an examination, to determine whether he or she would be admitted as a person under observation.

The Commission proposals generated mixed reactions, which demonstrated different perspectives about the mental health system. Although there was support expressed for the Commission suggestions, there were also concerns provided about privacy and safety. For example, some commentators considered the presence of peace officers to be appropriate, to guarantee the safety of a person being examined or of others. It was pointed out that while some facilities might have appropriate security personnel to observe and, if necessary, to physically restrain an individual who had been brought to a facility for examination, most do not. It was also suggested that information provided by facilities' staff to police officers when an examination is complete, and the individual is not being admitted as an involuntary patient, should be limited to a simple indication that the person does not fulfil the criteria for admission as a person under observation. Any further details would only be given with the patient's written consent. Otherwise, it was suggested, the traditional doctor/patient relationship would be altered. Other commentators did not believe that the police should be involved in the commitment process.

The Commission's proposal concerning clause 38(1)(b) produced little response. One commentator, however, suggested that clause 38(1)(b), which includes reference to committing or about to commit an indictable offence, can be of value to assist those mentally ill people involved with the criminal justice system. It was suggested that this provision allows people with mental illness to be diverted from the criminal justice system to receive treatment in the mental health system. The commentator suggested that if a person's crime was not one involving danger, but that the person was clearly ill and suffering great psychological harm, then the Commission's proposal would require this person to go through the trauma of jail, being charged, being placed on forensic remand and other procedures, where simple admission to hospital could have avoided this. It was suggested further that the term "indictable" should be deleted. This would prevent those people with mental illness who commit some minor crime from having to go through the criminal justice system at great costs to themselves and to society.

Affirming its Discussion Paper suggestion, the Commission agrees that hospital staff should be entitled to permit peace officers to leave a facility if a person apprehended and brought in for an examination did not appear to constitute a danger. As long as the personal safety of no one at a facility would be jeopardized, it serves no useful purpose for peace officers to remain at a facility until a psychiatric examination is completed. To avoid misunderstandings, permission for peace officers to depart should be in writing. The Commission affirms the need for a statutory provision requiring facility staff to inform peace officers of the admission or not of a person brought to a facility by peace officers. If a person is not admitted to a facility, the police might still wish to charge that individual. Keeping the police apprised of the result of a psychiatric examination will encourage them to bring people to a facility for examination, rather than having those people charged over an alleged criminal offence. The Commission recommends that the duty to inform the police should be "prior to discharge." Moreover, the duty to inform should apply whether a person was admitted or not. As a matter of consistency, the duty to inform would also extend to situations involving the discharge of a person who has been involuntarily admitted, so long as that person had been brought to a facility by the police.

After reviewing the comments received, and upon further reflection, the majority of the Commission agrees that clause 38(1)(b) should remain in the statute. This provision is still useful, as it enables peace officers to permit a person who seems to have a serious mental illness, and who was committing or about to commit an indictable criminal offence, to avoid the criminal justice system. To increase the effectiveness of this section, the majority of the Commissioners agrees that the qualifier "indictable" should be deleted from this clause. As a result, peace officers would be able to divert mentally ill persons from the criminal justice system for both serious and lesser criminal offences. The majority of the Commission agrees that the involuntary admission standard at section 38 should be consistent with that mentioned earlier in the Final Report. One of the Commissioners suggests, however, that clause 38(1)(b) is not necessary if the criterion "serious harm" is adopted at clause (a) of 38(1), as anything coming within the terms of (b) would also fall within the term "serious harm."

For the reason expressed in the Discussion Paper, namely that a person should have access to all relevant information relating to his or her admission to a facility, the Commission recommends that copies of relevant police reports should be included in a patient's psychiatric file.

The Commission recommends:

- Peace officers should be permitted to leave a facility during the time that a person apprehended and brought in by the officers is being examined. To avoid any misunderstandings, consent for peace officers to depart a facility should be in writing.
- Facility staff should be required to inform peace officers prior to discharge when a psychiatric examination of a person brought to a facility by peace officers is completed and the person is not admitted as an involuntary patient. The duty to inform should also apply if the person is admitted. As a matter of consistency, the duty to inform should extend to situations involving the discharge of a person who has been involuntarily admitted, so long as that person had been brought to the facility by the police.

The majority of the Commission recommends:

- At clause 38(1)(b) of the *Hospitals Act*, which provides for the apprehension of a disordered person "committing or about to commit an indictable offence," the term "indictable" should be removed.

The Commission recommends:

- Copies of relevant police reports should be included in a patient's psychiatric file.

5. Detention periods

a) Initial period of detention

Is the current duration of an initial admission certificate appropriate?

In provincial and territorial mental health law, the initial period of involuntary detention pursuant to an admission certificate (sometimes referred to as a "declaration of formal admission") ranges between two weeks and one month.[131] In Nova Scotia, a psychiatrist must decide within seven days whether or not to admit as an involuntary patient a person who has been under observation. Subsection 44(2) of the *Hospitals Act* states that no person is to be detained in a facility as an involuntary patient for an initial period longer than one month.

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[131] See Kingma, note 18, above, at 222-224.

The Discussion Paper suggested that in relation to the length of an initial detention period, a balance should be attempted. On the one hand, it was suggested, adequate time is needed to enable health care professionals to observe, interview and, if necessary, treat a patient. Too short an initial period might mean that health care professionals are not able to give their fullest attention. On the other hand, involuntary hospitalization involves a significant infringement of a patient's personal freedom. The Commission was of the view this infringement should be as short as necessary. The Commission took the position that an initial detention period of one month best balances the need to give health care professionals adequate time with the need to minimize intrusions on personal freedom. The *Hospitals Act* currently provides for an initial detention period of one month. The Discussion Paper therefore suggested this period should be retained.

The majority of comments received were in favor of this suggestion. In particular, it was suggested, a one month period provides a balance between fairness for patients and administrative practicality. A number of commentators, however, suggested that the Commission proposal meant concerns about resources, physicians' convenience, and expediency were being preferred to mental health consumer interests.

That a person has reached the involuntary patient stage is an indication of a serious mental health problem, one which in most cases formed the subject of two medical certificates, and which was confirmed by a psychiatrist after taking sufficient time to examine and assess the person. For the best interest of the patient, and for members of society, the Commission agrees, the statute should provide for an initial detention period which will allow a sound, careful diagnosis of a patient, and which will permit adequate treatment and care, yet which will not involve an unnecessarily long intrusion on personal freedom. The Commission recommends retaining the initial detention period of not longer than one month, as an amount of time which balances the needs of patients and requirements of health care professionals.

The Commission recommends:

- The current initial detention period of not longer than one month for an involuntary patient should be retained.

b) Renewal certificates

Should the duration for renewal certificates be maintained?

A person's initial involuntary hospitalization period can be extended if the original admission certificate is renewed. Similar provisions providing for the extension beyond the initial period of detention through the use of "renewal certificates" are found in most other provinces and territories.

In Nova Scotia, renewal, governed by section 44 of the *Act*, takes the form of examination by a psychiatrist, who may then certify that the patient should remain in the facility. Unless no other psychiatrist is available, an examination for the purpose of deciding on renewal must be done by a psychiatrist other than the one who signed the admission certificate or a previous renewal declaration. The criteria for issuing a renewal certificate are the same as for the initial admission certificate or a prior renewal declaration. An admission certificate can be renewed for up to a three-month period and a second period of up to three months. Any additional renewal period is for up to six months.

In most Canadian jurisdictions, the renewal periods eventually increase to either six months or one year. Ontario and Manitoba are atypical in limiting the maximum renewal period to three months, while both Saskatchewan and Yukon ordinarily limit each renewal period to 21 days.[132]

In the Discussion Paper, the Commission took the position that the length of renewal periods should reflect a balance between the need to properly evaluate a patient and the need to limit restrictions on a patient's personal freedom. If renewal periods are too short, it was suggested, then too many resources could be devoted to the review process. For instance, the Commission thought that as far as possible, psychiatrists should be involved in evaluating and treating patients, rather than being occupied with reviews. The Commission also cautioned, though, that if renewal periods are too long, in light of current psychiatric practice and available resources, then some patients may spend more time in hospital than is warranted. The Commission was of the view that an appropriate standard would be that proposed by the ULCC. Under the *Uniform Mental Health Act*,[133] an admission certificate can be renewed for a one-month period, followed if needed by a two-month period, in turn followed if required by a three-month period. Any additional renewal periods would be for three months.

The Discussion Paper was not in favour of altering the involvement of psychiatrists in the renewal process. Insisting in all cases on a psychiatrist who is different from the one who completed an assessment could be difficult to attain in practice, it was suggested. In some rural areas, it may not be possible to find more than one practising psychiatrist. The community of psychiatrists is also relatively small in Nova Scotia, and psychiatrists involved at the renewal stage might be reluctant to criticize opinions provided at the assessment stage. As the renewal process largely involves medical evaluation and the extent, if any, to which a patient's condition has improved, the Commission did not consider there to be a need to transfer the responsibility for renewal applications to a review board. As a result, the Commission suggested, the responsibility for renewal examinations should remain with psychiatrists. As is currently the case, unless no other psychiatrist is available, it was suggested that an examination for the purpose of a renewal certificate should be completed by a psychiatrist who was not involved in the initial admission certificate or a prior renewal certificate.

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[132] Ontario statute, note 94, above, s. 20; Manitoba statute, note 129, above, s. 21; Saskatchewan, S.S. 1984-85-86, c. M-13.1, s. 24; Yukon statute, note 110, above, s. 16.

[133] Note 96, above, s. 14.

Having said this, the Discussion Paper acknowledged the need for a review body to have the responsibility to resolve any disputes involving the nature or duration of renewals. These matters, it was suggested, should be heard by the review board, given its familiarity with mental health issues.

The same divisions that characterized comments concerning the initial period of detention were also exhibited in comments on the topic of renewal certificates. A number of commentators expressed support for the Commission proposals. For instance, one of these commentators suggested that wherever possible, a different psychiatrist should see a patient concerning an examination for the purpose of a renewal certificate, but that resource issues may make this impossible. Some commentators suggested that the Commission proposal in relation to detention periods represented only a small variation from the existing situation. It was suggested by these commentators that the Commission proposals ignored evidence of the better health outcomes in reducing periods of hospitalization and would require people to languish for unnecessarily long periods of time in facilities.

Having considered the comments received, the Commission affirms the proposals and reasons used in the Discussion Paper in relation to this issue. The Commission recommends that an admission certificate should be renewable for a period not to exceed one month, followed if needed by a period up to two months, in turn followed by a period up to three months. Any additional renewal periods would not exceed three months. This represents a significant reduction in relation to current renewal periods, yet should still allow sufficient time for thorough evaluation of any beneficial changes in a person's mental condition. The Commission recommends further that the responsibility for renewal examinations should remain with psychiatrists. Unless no other psychiatrist is available, an examination for the purpose of a renewal certificate should continue to be completed by a psychiatrist who was not involved in the initial admission certificate or a prior renewal. This acknowledges the benefits of a new perspective, but also takes into account this may not be feasible. Any disputes involving the nature or duration of renewals should be heard by the review board.

The Commission recommends:

- An admission certificate should be renewable for a period not to exceed one month, followed if needed by a period up to two months, in turn followed by a period up to three months. Any additional renewal periods would not exceed three months.

- The responsibility for renewal examinations should remain with psychiatrists.

- Unless no other psychiatrist is available, an examination for the purpose of a renewal certificate should continue to be completed by a psychiatrist who was not involved in the initial admission certificate or a prior renewal certificate.

- Any disputes involving the nature or duration of renewals should be heard by the review board.

B. TREATMENT

1. Mental capacity to consent to treatment

In order for a person to give a valid consent to treatment, he or she must be mentally capable. Mental capacity is an individual's ability to make reasoned decisions after weighing the risks, benefits, and other factors. A number of issues have arisen under the *Hospitals Act* concerning mental capacity to consent to treatment.

a) Capacity determination

When should a capacity determination occur?

At common law every person is presumed to be capable of making treatment decisions, until the contrary is determined. The fact that patients, whether voluntary or involuntary, are hospitalized in a psychiatric facility in order to obtain care and treatment for a mental disorder does not necessarily render them incapable of making psychiatric treatment decisions.[134] Section 51 of the *Hospitals Act*, however, requires every person admitted to a facility to be examined within three days of admission, in order to have his or her capacity to consent determined. Section 55 also provides for periodic capacity examinations of a person in a hospital. Sections 51 and 55 therefore do not seem consistent with the common law.[135]

In the Discussion Paper, the Commission took the position that for the benefit of patients and the guidance of mental health care professionals, an amended statute should make clear the common law presumption of a person being capable of making treatment decisions until the contrary is determined. The Commission was of the view that requiring every person admitted to a facility to be examined for capacity to consent to treatment is not consistent with the common law. As a result, the Commission suggested, the *Hospitals Act* should state explicitly that every person is considered capable of making treatment decisions until the contrary is determined.

The Commission was also of the view that a capacity determination should occur when needed, namely when an issue arises as to the person's capacity to consent to treatment. It was suggested, for example, that a psychiatrist may develop a concern about a patient's capacity if the patient objects to or refuses treatment. Another example might be where the patient insists on an unusual or unnecessary course of treatment.

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[134] *Fleming* v. *Reid* (1991), 4 O.R. (3d) 74 (C.A.) [hereinafter *Fleming* v. *Reid*] at 86.

[135] At s. 56, the *Hospitals Act*, note 50, above, contains a provision relating to the presumption of capacity, but its scope is unclear. Section 56 indicates that if a periodic examination is not conducted within the time frames set out in s. 55, then the person to be examined shall be presumed to be competent or capable of consenting to treatment until a psychiatrist determines otherwise. Section 56 does not refer to a presumption of capacity that applies when a person enters a facility.

All comments received in relation to this issue were in favour of the Commission suggestion that the *Hospitals Act* should refer explicitly to a presumption of mental capacity, unless otherwise determined. Where commentators tended to disagree, however, was with respect to deciding what event should trigger a capacity determination. For example, one commentator suggested that the triggering event would be a "significant issue," another supported the use of the term "reasonable grounds," while a third commentator suggested that capacity determinations should be "as needed." Other commentators suggested that the proposal concerning the presumption of capacity would be considerably undermined by the reference to a psychiatrist developing a concern about a patient's capacity if the patient objects to or refuses treatment. These commentators suggested that many patients who have full capacity to make treatment decisions might well object to or refuse treatment on any number of entirely reasonable and valid grounds, and that this alone should not be reason to be suspicious about a person's capacity.

Having taken into account the comments received, the Commission affirms its Discussion Paper suggestion concerning presumption of a person's capacity. The Commission is of the view that as a matter of guidance, both for patients and mental health care professionals, it would be helpful to set out the common law presumption in the statute. As a result, the Commission recommends that the *Hospitals Act* should state explicitly that every person is considered capable of making treatment decisions, until the contrary is determined. Upon further consideration, however, the Commission does not consider it helpful to attempt to identify situations which would justify undertaking a capacity determination. Rather, capacity determinations should take place on an as-needed basis, in accordance with generally accepted medical practices.

The Commission recommends:

- The *Hospitals Act* should state explicitly that every person is considered capable of making treatment decisions, until the contrary is determined.

- A capacity determination should take place only on an as-needed basis, in accordance with generally accepted medical practices.

b) Factors for determining capacity

Should the current factors for determining a person's capacity be revised?

Subsection 52(2) of the *Hospitals Act* requires a psychiatrist, in determining a person's capacity, to consider whether or not the person being examined:

- *(a)* *understands the condition for which the treatment is proposed;*
- *(b)* *understands the nature and purpose of the treatment;*
- *(c)* *understands the risks involved in undergoing the treatment;*
- *(d)* *understands the risks involved in not undergoing the treatment; and*
- *(e)* *whether or not his [or her] ability to consent is affected by his [or her] condition.*

In Ontario, a person is considered "capable" concerning treatment if the person is able to understand the information relevant to making a decision about the treatment and able to appreciate the reasonably foreseeable consequences of making a decision or not. Alberta uses the term "mental competence" in this context. A person is deemed mentally competent to make treatment decisions if able to understand the subject-matter relating to the decisions and able to appreciate the consequences of making the decisions.[136]

Under Yukon legislation, to be considered "mentally competent" a patient must understand:[137]

- (1) the condition for which treatment is proposed;
- (2) the nature and purpose of the treatment;
- (3) the risks involved in having the treatment; and
- (4) the risks in not having the treatment.

Manitoba and Prince Edward Island, similar to Nova Scotia, add a fifth stipulation, namely, whether the ability to consent is affected by the condition of the patient.[138]

There are no specific provisions for establishing capacity to consent to treatment in the legislation of British Columbia, New Brunswick, Newfoundland, Northwest Territories, Nunavut, Quebec, and Saskatchewan.

The Discussion Paper acknowledged there are some conditions which can impair a person's ability to provide a consent based on an appreciation of all relevant factors. If a mental disorder prevents a person from accepting that he or she has a particular condition, it was suggested, then any consent or refusal of consent by that person could not have followed an appreciation of all relevant factors. In the Discussion Paper, the Commission took the position that subsection 52(2), which sets out factors for a psychiatrist to consider in determining a person's capacity to consent to treatment, should remain unchanged.

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[136] *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 4; Alberta statute, note 104, above, s. 26.

[137] Yukon statute, note 110, above, s. 19.

[138] Manitoba statute, note 129, above, s. 24; P.E.I. statute, note 101, above, s. 23.

All comments received in relation to this issue were favorable. The Commission affirms its reasoning and its suggestion from the Discussion Paper and recommends that the factors at subsection 52(2) should remain unchanged.

The Commission recommends:

- The factors at subsection 52(2) of the *Hospitals Act,* which a psychiatrist must consider in determining a person's capacity to consent to treatment, should remain unchanged.

c) Capacity assessors

Who should assess capacity?

Section 53 requires all capacity determinations in a facility to be done by a psychiatrist. In the Discussion Paper, the Commission took the view that in addition to psychiatrists, other health care professionals may have the relevant combination of education and experience to qualify them to make capacity assessments. Rather than focusing on the designation of the health care professional involved, the Commission thought that relevant training and expertise are the keys. As a result, the Commission suggested that in addition to psychiatrists, other specially qualified health care professionals should be permitted to complete a capacity assessment. What combination of training and experience would meet the required qualifications would be a matter for organizations of health care professionals to determine.

For the most part, commentators were in favor generally of expanding the range of people who could assess capacity. However, in various ways, concern was expressed about the specific qualifications required in order to provide an assessment. A number of commentators suggested that a combination of expertise and training which would permit specially qualified individuals other than psychiatrists to complete capacity assessments had to be defined in the legislation. It was also suggested this would not be a simple undertaking and would require considerable review. Another commentator suggested that the initial assessment of capacity to consent to treatment should not be delegated to health care professionals who are not medically qualified and would therefore not be writing treatment orders.

Gauging a person's capacity to make important decisions is not confined to psychiatrists. For instance, under the *Incompetent Persons Act*, which governs the appointment of guardians to manage the finances and property of people who cannot manage their own affairs because of "infirmity of mind," "medical practitioners" and not simply psychiatrists may provide evidence relating to a person's capacity.[139] Also, a lawyer meeting with a client who wishes to have an enduring power of attorney prepared must be satisfied that the client understands the terms of the document and the possible consequences of its creation. The Commission is not suggesting that these contexts are the same as determining capacity to consent to psychiatric treatment. Nonetheless, in all three situations, the question of capacity must be addressed, in a manner which fulfills a number of objective criteria.

The Commission remains of the view that health care professionals with sufficient education and experience should be able to make a determination about a person's capacity to consent to treatment. This proposal is not meant to replace the role of psychiatrists; rather, by expanding the range of health care professionals permitted to complete a capacity assessment, it can free psychiatrists to fulfill other responsibilities. The Commission agrees that the question of appropriate qualifications and experience should not be approached lightly. For that reason, the Discussion Paper suggested that organizations of health care professionals, representing people who understand what combination of education and experience would qualify someone to make a capacity determination, should be consulted. Affirming its Discussion Paper suggestion, the Commission recommends that in addition to psychiatrists, other specially qualified health care professionals should be permitted to complete capacity assessments. Organizations of health care professionals should determine what combination of training and experience would meet the required qualifications.

The Commission recommends:

- In addition to psychiatrists, other specially qualified health care professionals should be permitted to complete capacity assessments. Organizations of health care professionals should determine what combination of training and experience would meet the required qualifications.

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[139] R.S.N.S. 1989, c. 218, s. 5.

2. Informed consent

Should the common law elements of informed consent, including the standard of disclosure, be made part of the legislation?

A physician is obliged to obtain a patient's consent prior to the administration of treatment. Consent can be written or oral. Written consent is generally seen as preferable, as it can make proof of what had been agreed easier in the event of a dispute. Consent can be express, as where a person provides consent in relation to a specific procedure. It can also be implied, as where one procedure necessarily forms part of another. For example, if a person requests a blood test and offers an arm, implicitly that person would be consenting to the drawing of blood from a vein.[140]

A valid consent must be: (1) specific to the proposed treatment; (2) given voluntarily; (3) given by a person who is mentally capable; and (4) informed.[141] In relation to the last factor, that consent be informed, the Supreme Court of Canada in *Hopp* v. *Lepp* imposed an obligation on Canadian physicians to disclose "the nature of the proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the performance of the operation."[142] In a subsequent decision, *Reibl* v. *Hughes*, the Supreme Court affirmed this standard and, among other things, proposed that disclosure should be based on whether a reasonable person in the same position as the patient would not have undergone the treatment if he or she had been properly informed of the risks.[143]

Subsection 54(1) of the *Hospitals Act* requires consent to be obtained before treatment is administered. It does not, however, explicitly state that the consent is to be "informed." Furthermore, the *Act* does not provide any elaboration with respect to the elements of consent or the standard of disclosure.

The mental health law of most other Canadian jurisdictions includes consent provisions, and most of those provisions are similar to the one in place in Nova Scotia. Ontario, however, sets out specific details about the elements of informed consent, including the required standard of disclosure. Section 11 of the Ontario *Health Care Consent Act, 1996* provides:[144]

> *(2) A consent to treatment is informed if, before giving it,*

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[140] E. Nelson, "The Fundamentals of Consent" in Downie & Caulfield, note 83, above, at 102.

[141] H. Savage & C. McKague, *Mental Health Law in Canada* (Toronto: Butterworths, 1987) at 100-105.

[142] [1980] 2 S.C.R. 192 at 210.

[143] [1980] 2 S.C.R. 880 at 897-898.

[144] Note 136, above.

(a) *the person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and*

(b) *the person received responses to his or her requests for additional information about those matters.*

(3) The matters referred in subsection (2) are:

1. *The nature of the treatment.*

2. *The expected benefits of the treatment.*

3. *The material risks of the treatment.*

4. *The material side effects of the treatment.*

5. *Alternative courses of action.*

6. *The likely consequences of not having the treatment.*

(4) Consent to treatment may be express or implied.

For the protection of patients' rights and for the guidance of psychiatrists, the Commission took the view in the Discussion Paper that the elements of informed consent should be set out in the *Hospitals Act* as they are identified in the Ontario legislation. The *Act* should indicate, it was suggested, that prior to receiving a particular treatment, a patient must provide his or her informed consent. This would mean that the patient was informed about the nature of the treatment, its expected benefits, its material risks, its material side effects, any alternative courses of action, and any likely consequences of not having the treatment. The Commission was also of the view that the elements of informed consent should be incorporated as part of any standard forms used in compliance with the *Act*. Forms would include a section for a psychiatrist to complete, in order to confirm that informed consent was discussed with a patient.

The Commission suggestions were generally seen as acceptable by commentators. Some people commented that increasing the level of direction in the statutory law is helpful, as it makes mental health consumers less subject to the uncertainties of the common law and of professional practices. Some concern was expressed, however, about how the elements of informed consent would be applied in practice. For example, one commentator questioned whether the Commission proposals would require written consent for every treatment, with treatment possibly ranging from psychotherapy to the use of aspirin. Another commentator suggested that an informed consent form should not be used to single out psychiatric patients; rather, such a form should be applied to all patients.

To gain a better appreciation of hospital policies and procedures relating to consent, following publication of the Discussion Paper the Commission took into account procedures for explaining and obtaining consent at the QE II Health Sciences Centre and the Nova Scotia Hospital. Consistent with those policies and procedures, the Commission assumes that upon a person's admission to a facility, an admission form, including a general consent section, will be completed for that person. The general consent section will provide consent to such aspects as routine x-rays or other non-invasive diagnostic testing. Prior to the administration of any treatment, however, specific consent will have to be obtained. The Commission affirms the elements of informed consent, as set out in the Discussion Paper, as being helpful both for health care professionals and patients. These elements should be set out in any standard forms used in compliance with the *Act*. What form consent should take, as well as what would be included as part of the agreed-upon treatment, would remain in accordance with generally accepted medical practices.

The Commission recommends:

- The *Hospitals Act* should specify that informed consent involves explaining to a patient the nature of the treatment, its expected benefits, its material risks, its material side effects, any alternative courses of action, and any likely consequences of not having the treatment.
- The elements of informed consent should be set out in any standard forms used in compliance with the *Act*.
- What form consent should take, as well as what would be included as part of the agreed-upon treatment, would remain in accordance with generally accepted medical practices.

3. Consent to treatment and compulsory treatment

a) Compulsory treatment

Should compulsory treatment be allowed under certain circumstances?

At common law, everyone has the right to refuse unwanted medical treatment.[145] This common law principle was considered in the context of psychiatric treatment in *Fleming v. Reid*. In that case, the Ontario Court of Appeal stated that a capable person was entitled to control the course of his or her medical treatment. A capable person's right to self-determination was not forfeited when he or she entered a psychiatric facility.[146]

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[145] *Malette* v. *Schulman* (1990), 72 O.R. (2d) 417 at 424 (C.A.).

[146] *Fleming* v. *Reid*, note 134, above, at 86.

An issue which arises here is whether compulsory treatment can be administered in certain circumstances to patients with mental illness. Subsection 54(1) of the *Hospitals Act* provides the general rule that no person admitted to a hospital shall receive treatment unless he or she consents. However, in accordance with subsection 54(2), if a person in a facility is not capable of consenting to treatment, that person may be treated if consent is obtained from his or her guardian, spouse or common-law partner or next of kin, or the Public Trustee.

In Newfoundland, treatment can be given without consent to a person who is an involuntary patient and who is not capable of consenting to treatment, and in British Columbia, an involuntary patient is deemed to have consented to the treatment authorized by the director of the mental health facility.[147] Under Alberta law, a review panel can order treatment over the objections of an involuntary patient, if the panel determines that the treatment is in the patient's best interest.[148] Legislation in Ontario allows a review board to override the consent or refusal to consent of patients and substitute decision-makers, under certain circumstances.[149] Manitoba legislation permits a review board to override the refusal to consent to treatment by a patient's competent proxy or a patient's nearest relative.[150]

Under the *Uniform Mental Health Act*, an involuntary patient has the right not to be given psychiatric treatment or other medical treatment without his or her consent, a consent made on his behalf, or an order of the review board authorizing such treatment. Before authorization, the review board must be satisfied that the mental condition of the patient will either be substantially improved by the treatment or will not improve without the treatment and that the benefit to the patient will outweigh the potential risk of harm.[151]

In the Discussion Paper, the Commission took the view that generally, treatment should only proceed when a patient has provided his or her consent. Consent can be given by a patient directly, or a patient, while still mentally capable, can communicate in advance his or her wishes concerning health care, in a document known as an advance health care directive, which anticipates the possibility of future mental incapacity. The advance health care directive may appoint a representative, known as a "substitute decision-maker" or "proxy," to make health care decisions, may set out general principles or specific instructions about how a person's health care is to be managed, or may do both. In Nova Scotia, though, the *Medical Consent Act* only provides for the use of a proxy-type advance health care directive.[152] However, in those situations for which a person has not appointed a proxy through an advance health care directive and has become mentally incapable, the majority of the Commission took the view that it should be possible for a review board to approve compulsory treatment.

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[147] Newfoundland statute, note 94, above, s. 5; B.C. statute, note 103, above, s. 31.

[148] Alberta statute, note 104, above, s. 29. A recent Alberta case held that if a patient with a mental disorder could express neither his or her consent nor objection to the proposed course of treatment, then the patient should not be deemed to have objected to the treatment. As a result, the review panel could not impose the proposed treatment: *B.(M.)* v. *Alberta (Minister of Health)* (1998), 149 D.L.R. (4th) 363 at 370 (Alta. Q.B.).

[149] In *M.(A.)* v. *Benes* (1999), 180 D.L.R. (4th) 72 (Ont. C.A.) the Ontario review board's ability to override a substitute decision-maker's choice concerning treatment, where there were no prior expressed wishes, was upheld.

[150] Manitoba statute, note 129, above, s. 30.

[151] ULCC statute, note 96, above, ss. 25-26.

This suggestion resulted in a variety of responses. There was support for the Commission proposal, subject to the conditions specified in the Discussion Paper. A number of commentators, however, suggested that the Commission proposal seemed to eliminate the role of substitute decision-makers or proxy decision-makers in situations of incapacity, unless an advance health care directive applied. These commentators asked for clarification whether or not the Commission was suggesting the elimination of the role of substitute decision-makers as presently provided for under the legislation. An advantage of properly regulated substitute decision-makers, these commentators suggested, was being much better aware of a patient's wishes, as expressed when he or she was competent, than could be determined by a Board.

The majority of the Commission affirms its Discussion Paper suggestions in relation to this issue. Although in general informed consent should be necessary for treatment to take place, people in need of certain treatment should not have to languish when they are mentally incapable, and because of circumstances, there is no one to provide substitute consent. Having said this, the Commission wishes to add a number of qualifying statements, as a matter of clarity. The Commission has in mind involvement of a review board in this context only in such instances where there is no proxy appointed through an advance health care directive, as well as no statutory substitute decision-maker available under subsection 54(2). Whether deriving their authority from an advance health care directive or through the *Act*, substitute decision-makers perform the important responsibility of acting on behalf of, and in the best interest of, people who through incapacity cannot make their own health care decisions.

The Commission acknowledges the valuable role fulfilled by substitute decision-makers, which is discussed in more detail at III.B.3c. Moreover, the type of compulsory treatment contemplated here would take place within a facility, to distinguish it from treatment taking place in the community, which is discussed at III.B.7.

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[152] R.S.N.S. 1989, c. 279. For additional discussion of advance health care directives, see Part III.B.6, below.

The majority of the Commission recommends:

- In those situations for which a person has not appointed a proxy through an advance health care directive, and there is no statutory decision-maker available, it should be possible for a review board to approve compulsory treatment within a facility if the person has become mentally incapable. Before authorization, the review board must be satisfied that the mental condition of the patient will either be substantially improved by the treatment or will not improve without the treatment and that the benefit to the patient will outweigh the potential risk of harm.

b) Psychosurgery and other specialized psychiatric treatment

Should the statute allow psychosurgery? Should there be a specific consent provision for other specialized psychiatric treatment?

In addition to its general consent provisions, section 60 of the *Hospitals Act* refers to the consent requirements associated with psychosurgery, including the requirement that a patient must consent to psychosurgery.[153] Comparable provisions are found in the mental health legislation of other Canadian jurisdictions.

The infrequent use of psychosurgery in Nova Scotia gives rise to the question whether or not the province's mental health legislation should continue to include a provision related to psychosurgery, and if so, whether this should be expanded to include other specialized psychiatric treatment, such as electroconvulsive therapy (ECT).

The Commission took the position in the Discussion Paper that the most effective approach for dealing with unusual types of treatment is found in New Brunswick. Rather than attempting a list of what is unusual treatment, the New Brunswick statute defines routine clinical medical treatment. It is referred to as "generally recognized and acceptable psychiatric treatment and other generally recognized and acceptable medical treatment that is necessary to effectively treat a mental disorder."[154] Extraordinary types of treatment must be approved by a review board. The Commission suggested this approach is more effective, as it frees the Legislature from having to identify and define unusual forms of treatment and places the burden of establishing the need for an atypical procedure on those who seek to employ it. The Commission was also of the view that the New Brunswick provision strikes a balance between protecting people from unproven forms of treatment and allowing medicine to progress through the development of new treatment. The Commission therefore suggested that the *Hospitals Act* should define routine clinical medical treatment, with extraordinary types of treatment to be approved by a review board.

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[153] Psychosurgery is brain surgery for the purpose of treating a mental disorder: J.M. Hawkins & R. Allen, eds., *The Oxford Encyclopedic English Dictionary* (Oxford: Clarendon Press, 1991) at 1167. During the past 18 years, no hearings have been held by the Psychiatric Facilities Review Board to determine whether psychosurgery could be performed: Nova Scotia, Psychiatric Facilities Review Board, *Annual Report: April 1, 1999 - March 31, 2000* ([Halifax: The Board, 2000]) at 4.

[154] N.B. statute, note 112, above, s. 1.

These proposals did not meet with much agreement among commentators. One commentator suggested that extraordinary types of treatment such as ECT should be defined in legislation, along with a clause which would allow other new types of treatment to be included as well. Rather than defining "routine" and "extraordinary" treatment, another commentator preferred that the legislation refer to "standard and evidence - based practice which is subject to peer review and monitored by institutions." Other commentators also considered the Commission preference for routine and extraordinary types of treatments to be unhelpful. Rather, these commentators preferred the use of a list, to be compiled with the assistance of mental health consumers, identifying particular types of treatment where heightened procedural protection was required. Another commentator suggested that involving a review board in decisions about specialized psychiatric treatment was both unnecessary, given the requirement for informed consent, and inappropriate, given that it could result in significant delays in patients receiving routine and effective medical treatment.

For the reasons provided in the Discussion Paper, the Commission affirms its suggestions on this issue. However, the Commission wishes to make clear the qualification that if no consent is forthcoming, from a patient, a proxy appointed under an advance health care directive or a statutory decision-maker, then no extraordinary treatment should take place. In other words, the role of a review board in the context of extraordinary treatment is to provide institutional monitoring, an added protection for patients. This role is not meant as a substitute for consent on the part of a patient or someone who represents the patient.

The Commission recommends:

- **The *Hospitals Act* should define routine clinical medical treatment, with extraordinary types of treatment to be approved by a review board.**
- **Routine clinical medical treatment should be defined as "generally recognized and acceptable psychiatric treatment and other generally recognized and acceptable medical treatment that is necessary to effectively treat a mental disorder."**

c) Substitute consent and substitute decision-makers

How should a substitute decision-maker make decisions on behalf of another person? What if a dispute arises among substitute decision-makers?

With the exception of British Columbia and Newfoundland, substitute consent provisions are included in the law of all provinces and territories. In Nova Scotia, if a person in hospital is incapable of consenting to treatment, subsection 54(2) of the *Hospitals Act* permits treatment of the person if consent is obtained, from the person's guardian, spouse or common-law partner or next of kin, or the Public Trustee. Commenting on this type of provision, a recent mental health law text explained that once one of the identified decision-makers decides, either in favour of or against treatment, the consultation process ends:[155]

> *The physician must approach the person at the top of the list. If that person is qualified to be a substitute decision-maker and agrees, treatment proceeds. If the person disagrees, no treatment can be given. If the person declines to make a decision or cannot be located, the next person on the list is contacted, and so on, until a decision is made. It is not permitted to "shop" for the most favourable decision-maker on the list – if one person consents or refuses, the process stops.*

The *Hospitals Act* does not offer any guidance as to what factors should be considered by substitute decision-makers. Section 2 of the *Medical Consent Act* also allows a person who is 19 years of age and capable of giving consent to medical treatments to authorize another adult to give that consent at a future time when the person giving the authorization is no longer capable.[156]

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[155] Gray, Shone & Liddle, note 20, above, at 181.

[156] Note 152, above.

The *Uniform Mental Health Act* provides that a substitute decision-maker is to base his or her consent or refusal on the wishes, if clearly known, of the patient, expressed when the patient was mentally competent and sixteen or more years of age. Otherwise, consent is to be given or refused in accordance with the best interest of the patient. Best interest is to be determined according to:[157]

i) whether or not the mental condition of the patient will be or is likely to be substantially improved by the specified psychiatric treatment;
ii) whether or not the mental condition of the patient will improve or is likely to improve without the specified psychiatric treatment;
iii) whether or not the anticipated benefit from the specified psychiatric treatment and other related medical treatment outweighs the risk of harm to the patient; and
iv) whether or not the specified psychiatric treatment is the least restrictive and least intrusive treatment that meets the prior three requirements.

Whether appointed through an advance health care directive or by virtue of legislation, it is possible that more than one substitute decision-maker of the same rank could exist. The legislation in most Canadian jurisdictions, including the *Hospitals Act*, does not mention how to resolve disputes among substitute decision-makers of the same rank.

The ULCC *Uniform Act* does address this issue. It provides, at clause 26(1)(c), that the attending physician of an involuntary patient may apply to the review board for an order authorizing treatment if, among others, two or more persons occupying the same rank in the list of substitute decision-makers claim the authority to give or refuse consent for the patient. This approach is followed in the Northwest Territories, Nunavut, and Yukon.[158] In P.E.I., subsection 23(6) of the *Mental Health Act*[159] seems to indicate that if a patient does not have a guardian, then the attending psychiatrist may choose the most appropriate substitute decision-maker. By virtue of clause 28(1)(e), an application to the review board by any person acting on behalf of an involuntary patient may be made for a review of the choice of substitute decision-maker. For conflicts among substitute decision-makers of the same category in New Brunswick, the legislation allows the person seeking the consent to treatment to file an application with the review board.[160] In Ontario, when two or more persons are part of the same category of substitute decision-makers, if both claim the authority to consent or refuse, if they disagree about the decision, and if there are no other claims of higher authority, then the Public Guardian and Trustee will make the decision for them.[161]

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[157] Note 96, above, s. 24.

[158] N.W.T. statute, note 110, above, s. 19.3 (adopted in Nunavut); Yukon statute, note 110, above, s. 23.

[159] P.E.I. statute, note 101, above.

[160] N.B. statute, note 112, above s. 8.6(5).

In the Discussion Paper, the Commission acknowledged that being a substitute decision-maker is a significant and perhaps daunting responsibility. The Commission was of the view that the *Hospitals Act* should provide guidance for substitute decision-makers. The first factor to consider would be any prior expressed wishes. If there were none, or if they were unclear, then the best interest of the patient would be taken into account. The Commission suggested that factors equivalent to those in the *Uniform Mental Health Act* should be adopted to help determine a patient's best interest.

In the event of a dispute between substitute decision-makers of the same rank, the Commission did not consider it appropriate for the treating psychiatrist to resolve the impasse or to proceed on his or her own initiative. The psychiatrist might not be perceived as impartial, it was suggested, as he or she would have the same opinion on the need for treatment as one of the disputing substitute decision-makers. Rather, the Commission thought that an objective third party, namely the review board, should resolve disputes between substitute decision-makers. The Commission suggested that in the event of a dispute between substitute decision-makers of the same rank, either a substitute decision-maker or the treating psychiatrist could apply to the review board, in order to have the dispute resolved.

For the most part, commentators agreed on the potential role of substitute decision-makers, subject to taking into account any prior expressed wishes by a person. Some commentators suggested, however, that the relevant standard to govern substitute decision-makers had to be identified. It was suggested this would ensure decisions were not made on an arbitrary basis, did not result from undue deference to physicians, and did not occur in spite of a mental health consumer's wishes and values.

The Commission remains of the view that its suggestion concerning how substitute decision-makers should proceed is easy to understand and sufficiently specific to provide proper direction. The first duty of a substitute decision-maker is to determine whether or not any prior expressed wishes apply to the situation at hand. If not, then the substitute decision-maker is not to proceed on a whim; rather, his or her decision must be justifiable in light of a number of objective factors, which taken together, are considered to represent a patient's "best interest."

The Commission recommends that a substitute decision-maker should be required to take into account any prior expressed wishes by a person. If there are no prior expressed wishes, or if they are unclear, then a substitute decision-maker should take a person's best interest into account. Best interest should be determined according to:

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[161] Ontario, *Health Care Consent Act*, note 136, above, s. 20(6).

i) whether or not the mental condition of the patient will be or is likely to be substantially improved by the specified psychiatric treatment;
ii) whether or not the mental condition of the patient will improve or is likely to improve without the specified psychiatric treatment;
iii) whether or not the anticipated benefit from the specified psychiatric treatment and other related medical treatment outweighs the risk of harm to the patient; and
iv) whether or not the specified psychiatric treatment is the least restrictive and least intrusive treatment that meets the prior three requirements.

The Commission affirms its recommendation that in the event of a dispute between substitute decision-makers of the same rank, either a substitute decision-maker or the treating psychiatrist could apply to the review board, in order to have the dispute resolved.

The Commission recommends:

- A substitute decision-maker should be required to take into account any prior expressed wishes by a person. If there are no prior expressed wishes, or if they are unclear, then a substitute decision-maker should take a person's best interest into account.

- Best interest should be determined according to:

    i) whether or not the mental condition of the patient will be or is likely to be substantially improved by the specified psychiatric treatment;
    ii) whether or not the mental condition of the patient will improve or is likely to improve without the specified psychiatric treatment;
    iii) whether or not the anticipated benefit from the specified psychiatric treatment and other related medical treatment outweighs the risk of harm to the patient; and
    iv) whether or not the specified psychiatric treatment is the least restrictive and least intrusive treatment that meets the prior three requirements.

- In the event of a dispute between substitute decision-makers of the same rank, either a substitute decision-maker or the treating psychiatrist could apply to the review board, in order to have the dispute resolved.

4. Emergency exception to consent requirement

Should there be a statutory emergency exception provision?

Although the informed consent of a patient or substitute decision-maker is generally required before the administration of treatment, an exception applies in the event of an emergency. Consent may be dispensed with in certain situations where the patient is not able to provide consent and the patient's life or health is in danger.[162] This is known as the emergency exception or the doctrine of necessity. The emergency exception will not apply, however, where it is merely convenient for a physician to proceed without a patient's consent.[163] The emergency exception will also not be available where the patient, prior to the emergency situation, clearly indicated disagreement with a particular procedure.[164]

The emergency exception has been specifically mentioned in a number of provincial and territorial mental health statutes. For example, the Ontario *Health Care Consent Act* states that an "emergency" exists "if the person for whom the treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm."[165] A treatment may be administered without consent to a person who is incapable with respect to the treatment, if, in the opinion of the health practitioner proposing the treatment, there is an emergency and the delay required to obtain a consent or refusal on the person's behalf will prolong the suffering that the person is apparently experiencing or will put the person at risk of sustaining serious bodily harm.

In Nova Scotia, the *Hospitals Act* does not provide for the administration of treatment, without consent, in the event of an emergency. Consistent with the common law, however, if a delay in treatment will threaten the life or health of the patient, the physician may proceed without obtaining consent. When a patient has no advance health care directive and no next of kin, and a physician does not wish to proceed solely on the basis of the common law, then consent for treatment would have to be obtained from the Public Trustee.[166] Depending on when a consent request is received, it would be several days before the Public Trustee's office collects enough information on which to base a decision.

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[162] *Marshall* v. *Curry*, [1933] 3 D.L.R. 260 at 275 (N.S.S.C.).

[163] *Murray* v. *McMurchy*, (1949) D.L.R. 442 (B.C.S.C.).

[164] *Malette* v. *Shulman* (1990), 67 D.L.R. (4th) 421 at 424 (Ont. C.A.).

[165] Note 136, above, s. 25.

[166] The Public Trustee is a government office that may be appointed, among other matters, to act as a guardian for a person who is found to be mentally incompetent. Depending on the context, the Public Trustee may be involved under the *Hospitals Act*, note 50, above, in applying for the discharge of a person [s. 47], providing consent to treatment [ss. 54 and 60], applying for a review of a capacity or competency declaration [s. 58], intervening to preserve and protect the property of a person subject to a competency declaration [s. 59] and providing consent to the disclosure of a person's hospital records [s. 71].

In the Discussion Paper, the Commission took the position that to protect the health of patients, while at the same time upholding their right in general to consent to treatment, as well as to provide guidance and reassurance to physicians, an emergency exception concerning treatment should be included in the *Act*. The Commission was of the view that the Ontario approach to this issue reflected the common law. As a result, the Commission suggested, the statute should specifically allow for treatment to be administered without the consent of a person who is incapable of giving it with respect to the treatment, if there is an "emergency." An emergency, it was suggested, should be found to exist if the person for whom treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm.

Although a number of commentators agreed in general with the basis for this proposal, they differed about the specifics. One commentator suggested that the issue of treatment being administered without consent to an incapable person should not be limited to emergencies, as by definition this would lead to inadequate treatment. Other commentators suggested that the qualifier "mental or physical" should be inserted immediately before "severe suffering" as part of the criteria of an emergency, as suffering can otherwise be interpreted in a narrow physical pain sense. Although agreeing with the rationale for the Commission's suggestion, one commentator stated it was not strictly necessary. Other commentators expressed the concern that the Commission proposal would considerably widen the existing common law emergency exception to the normal consent requirement, to the point where almost anyone with certain kinds of illnesses could be deemed to be experiencing severe suffering.

The Commission affirms its suggestion from the Discussion Paper that the statute should specifically allow for treatment to be administered without consent in the event of an emergency to a person who is incapable with respect to consent to the treatment. Nonetheless, taking into account the comments received, the Commission is of the view that in the interest of flexibility, the term "emergency" not be defined in the *Act*. The Ontario "severe suffering" standard seems to go beyond the common law conception of an emergency involving a danger to life or health. One can imagine situations in which a person is experiencing severe suffering, but does not face death or serious harm. As a result, the Commission recommends that the statute should specifically allow for treatment to be administered without consent in the event of an emergency to a person who is incapable with respect to consent to the treatment.

The Commission recommends:

- The statute should specifically allow for treatment to be administered without consent in the event of an emergency to a person who is incapable with respect to consent to the treatment.

5. Liability of health care professionals

Health care professionals might have concerns about possible legal consequences following the fulfillment of their responsibilities under the *Hospitals Act*. For instance, a patient who believes that he or she has suffered a legal wrong during the course of a stay at a facility might commence a legal action for damages against certain health care professionals, One ground for a legal action might be battery, which involves intentionally bringing about an offensive or harmful contact with another person.

The Commission is of the view that health care professionals who attempt to fulfill their *Hospitals Act* responsibilities reasonably and in good faith should not be subject to legal action concerning the performance of those responsibilities. Otherwise, concern over potential liability might cause some health care professionals to avoid taking certain action which in most cases will be beneficial for patients. One instance might involve a refusal to use medically accepted means of restraint, in order to prevent a patient from causing bodily harm. The Commission therefore recommends that the *Hospitals Act* should include a section which exempts from liability any person acting reasonably and in good faith in the course of his or her responsibilities under the *Act*.

The Commission recommends:

- The *Hospitals Act* should include a section which exempts from liability any person acting reasonably and in good faith in the course of his or her responsibilities under the *Act*.

6. Advance health care directives

How should advance health care directives be treated in the *Act*?

An advance health care directive allows an adult who is mentally capable to make decisions for future medical treatment or non-treatment in anticipation of future mental incapacity. In its

1995 Final Report on adult guardianship and advance health care directives, the majority of the Law Reform Commission of Nova Scotia made a number of recommendations concerning advance health care directives.[167] The Commission recommended that the law should allow a person to set out instructions or general principles about future health care decisions. This would be in addition to allowing a person to appoint a proxy to follow instructions and interpret general principles concerning health care decisions set out in a directive or to make health care decisions on the maker's behalf. The Commission took the position that an advance health care directive should be effective whenever a person was incapable of making health care decisions. The Commission was in favour of a duty to follow the instructions contained in the directive unless there were compelling reasons for not doing so. A proxy would have a duty to act according to what he or she knew of the maker's wishes or, if unknown, according to the maker's best interests. The proxy would not be allowed to delegate decision-making authority to another person, and there would be limits on what a proxy could consent to on behalf of the maker unless specifically authorized.

The current Nova Scotia law on advance health care directives, which is found in the *Medical Consent Act*,[168] only refers to proxies. An advance health care directive which uses instructions is not expressly allowed under Nova Scotia law. The rest of this section, however, pertains only to instructional directives and would require implementation of the Commission's 1995 report before being relevant to the *Hospitals Act*.

In the Discussion Paper, the majority of the Commission acknowledged that for the most part, people should be able to make their own decisions concerning their personal health. It is also possible, the Commission suggested, that a person's instructions about future health care lack clarity or comprehensiveness. For example, an advance health care directive may fail to address a particular situation. Moreover, an advance health care directive may have been created at a time when certain procedures or treatment were not available. Had the maker of the advance health care directive known about certain medical innovations, his or her instructions may have been different. The majority of the Commission affirmed that a person who is mentally capable can refuse all treatment. However, the majority of the Commission also took the position that where a person is no longer mentally capable, certain circumstances could justify not following an advance health care directive. The majority of the Commission suggested it may be justifiable not to follow an advance health care directive in light of medical developments not available at the time the advance health care directive was created. The Commission invited suggestions about what other compelling circumstances might justify not following an advance health care directive.

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[167] Law Reform Commission of Nova Scotia, *Reform of the Laws Dealing with Adult Guardianship and Personal Health Care Decisions* (Final Report) (Halifax, N.S.: The Commission, 1995) at iii-iv.

[168] Note 152, above.

Comments received did not reflect any consensus. A number of commentators suggested that the Commission proposal made it comparatively easy to circumvent an appropriate and binding health care directive. These commentators questioned the appropriateness of "medical developments" as a reason for overriding a directive. It was also suggested that the Commission should consider the ability of persons to update their health care directives. Another commentator indicated that the availability of medical developments, not at hand when a directive was created, should not be sufficient to justify ignoring the directive. From the perspective of another commentator, assuming that a competent patient or a valid advance directive refuses the treatment required for the patient to get well enough to be discharged from hospital, there are four major reasons why refusal of the treatment required to release the patient from involuntary detention should be overruled: detention without treatment is illogical; detention without treatment may be contrary to the *Charter*; harm may result from treatment refusals; and physicians and nurses may be placed in unethical positions because the law forces them to take actions which they know will damage patients.

The Commission acknowledges that an advance health care directive should not be easily overridden. Otherwise, such a document would be meaningless. The majority of the Commission nonetheless remains concerned about the appropriateness of putting into effect a directive when relevant factors at the time of application differ significantly from those in existence when the document was created. From the Commission's perspective, certain assumptions formed the basis for the creation of a directive. If the conditions which led to those assumptions disappear or are substantially altered, then the reason for applying a directive's instructions may also have disappeared. Medical developments come most readily to mind. For instance, a person might refuse certain medication because of concerns about side effects. Over the course of time, improvements might lessen or eliminate the side effects. Choosing not to follow an advance health care directive could seem especially compelling where a mentally incapable person engages in dangerous behaviour which results in restrictions to his or her freedom, and which would otherwise be controlled through the use of certain medication.

The majority of the Commission recommends that where a person is no longer mentally capable, an advance health care directive should be overridden, if medical developments, not known at the time of the directive's creation, are sufficiently compelling to justify not following the directive.

The majority of the Commission recommends:

- **Where a person is no longer mentally capable, an advance health care directive should be overridden, if medical developments, not known at the time of the directive's creation, are sufficiently compelling to justify not following the directive.**

7. Provision of compulsory mental health treatment in the community

In certain circumstances, should there be compulsory treatment in the community for involuntary patients?

Not all involuntary patients in Canada remain confined to a facility while they are receiving treatment. As an alternative, some patients are permitted to live in the community, so long as they follow a treatment schedule and other conditions. For instance, a patient might have to prove that he or she continues to take prescribed medication. The programs whereby involuntary patients can return to the community have been compared to a type of parole. If patients do not respect the conditions of the program, they can be committed once again to a facility. The mechanisms for the return of involuntary patients to the community are known as "community treatment orders" or "leave certificates." A community treatment order is a legal mechanism which provides for the compulsory treatment of a patient who lives in the community, subject to a number of conditions and restrictions.[169] Leave certificates are similar, in that they allow involuntary patients to return to the community and receive treatment there. Unlike community treatment orders, leave certificates involve treatment plans to which a patient or the patient's representative has consented.[170]

In Nova Scotia, the law does not provide for community treatment orders or leave certificates. Physicians are restricted to providing treatment for involuntary patients in an in-patient hospital setting. Saskatchewan is presently the only jurisdiction in Canada which allows for the involuntary treatment in the community of persons with mental illness. However, community treatment with some compulsory aspect is in place in Alberta, Manitoba, British Columbia, Prince Edward Island, and Ontario.[171]

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[169] Manitoba, Department of Health, Mental Health Act Review Committee, *Potential Amendments to the Mental Health Act* (N.p.: [Minister of Health], 1996) at 17.

[170] See, for example, Manitoba statute, note 129, above, s. 46.

What sets the Saskatchewan legislation apart from other community treatment schemes is its mandatory nature. Saskatchewan's community treatment orders apply to involuntary patients who are unable to fully understand and to make an informed decision about their need for treatment or care and supervision. Otherwise, the community treatment details in Saskatchewan are similar to those in Manitoba.

Manitoba legislation provides for the treatment of patients with mental disorders under "leave certificates."[172] A leave certificate is meant to provide a patient with psychiatric treatment that is less restrictive and less intrusive to the patient than being detained in a facility. The leave certificate allows a patient or the patient's representative to consent to a treatment plan proposed under such a certificate. A leave certificate may be issued if a patient: during the previous two years, has been a patient in a facility for at least 60 days; has been a patient in a facility on three or more separate occasions; or has been the subject of a previous leave certificate. A treatment plan must be developed, and the patient is entitled to participate in the plan's development. The patient or the patient's representative must consent to the treatment plan in order for a leave certificate to be issued. Criteria for issuing a leave certificate also include:

- the person must be suffering from a mental disorder for which he or she needs continuing treatment or care and supervision while living in the community;
- the patient is likely, because of the mental disorder, to cause serious harm to himself or herself or to another person, or to suffer substantial mental or physical deterioration if the patient does not receive continuing treatment or care and supervision while living in the community;
- the patient is capable of complying with the leave certificate requirements; and
- the treatment or care and supervision described in the leave certificate exists in the community and can and will be provided in the community.

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[171] Alberta statute, note 104, above, ss. 46-48; B.C. statute, note 103, above; P.E.I. statute, note 101, above, s. 25; Ont. statute, note 94, above, ss. 33.1-33.9. New Brunswick recently undertook a consultation process with 80 stakeholders to consider the implementation of community treatment and outpatient committal options. A decision was made to use the "extended leave" provisions already provided for in its *Mental Health Act*; to strengthen proactive community treatment programs; and to provide more education about the current law. [Telephone conversation with Mr. Luc Doucet, Chief Patient Advocate for New Brunswick (7 July 1999)]. A recent United Kingdom consultation paper has also made recommendations for compulsory community care and treatment: U.K., H.C., "Reform of the Mental Health Act 1983: Proposals for Consultation" Cm 4480 (1999) at 37-39.

[172] Note 129, above, ss. 46-48.

A patient for whom a leave certificate is issued acquires the status of voluntary patient. Ordinarily, the duration of a leave certificate is not more than six months, which can be extended. A leave certificate can be reviewed. A certificate can also be cancelled if a psychiatrist believes, on reasonable grounds, that a patient could be a danger.

In the Discussion Paper, the Commission suggested that on balance, it would be more helpful than not to allow for the possibility of treatment in the community. It was suggested this treatment option could free certain patients from the intrusiveness of compulsory hospitalization and allow them the opportunity to assume more normal lives in the community. As this approach involves a continuity of treatment, it could help to avoid the cycle of patients who continue to be discharged from a facility, only to return, with a deterioration in their mental state, when they do not adhere to their treatment schedule. The Commission was of the view that community treatment approaches are more conducive to allowing patients to participate in determining the nature of their treatment. It was also suggested that this participation might increase the chance that patients will adhere to their treatment plan.

The Commission's Discussion Paper supported the implementation of a program of leave certificates as was devised in Manitoba. In order for a leave certificate to be issued, the patient would have to suffer from a mental disorder for which he or she needs continuing treatment or care and supervision while living in the community. Consistent with other Discussion Paper suggestions about the criteria for civil commitment, the patient would have to be considered likely, because of the mental disorder, to cause bodily harm to self or others, to cause psychological harm to self, or to suffer imminent and serious impairment if the patient does not receive continuing treatment or care and supervision while living in the community. A collaborative treatment plan would be developed, to which the patient or the patient's representative consents. The patient would have to be capable of complying with the leave certificate requirements. The treatment or care and supervision described in the leave certificate would have to exist in the community and could and would be provided in the community.[173]

This issue generated a considerable number of comments, which tended to be polarized, either strongly in favor or against the use of compulsory community treatment. Some commentators were of the view that some type of compulsory community treatment would be beneficial, as it would be less intrusive than involuntary commitment at a facility. Moreover, they suggested, it would prevent the problem of patients who refuse treatment and who are simply confined at a facility with no apparent benefit. Other commentators suggested that community treatment would free them from having to watch helplessly as a person with mental illness deteriorates, ultimately becomes dangerous, and must again be committed to a facility. In the meantime, these people with mental illness, it was suggested, cause further pain for themselves and family members and eventually must spend additional time in psychiatric facilities. In other words, community treatment orders, if properly regulated, could ensure the security of the patient in the community treatment setting, prevent recurrent hospitalization, and ensure continuity of treatment.

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[173] The Commission is of the view that the creation of a leave certificate program should not be used to justify reducing the budget for medication which is currently funded by Government on behalf of those people committed to facilities.

One commentator suggested that if a person with mental illness will not be held legally responsible for his or her criminal actions, then it should not be expected that such a person could be trusted to take medication on his or her own initiative, especially with a previous record of non-compliance. Another comment was that the inability of the civil psychiatric system to treat most patients effectively has contributed to greater numbers of mentally ill people coming into contact with the criminal justice system and being subject to commitment orders under the *Criminal Code*.

Those commentators not in favor of community treatment suggested that it was unduly intrusive, and that its effectiveness was not proven. Critics of community treatment suggested that it involves an overemphasis on conventional treatment, especially medication, which may be dangerous, and underemphasis on other needs of the patient for social and community supports known to improve health outcomes. Rather than an emphasis on community treatment, it was suggested that other initiatives, such as crisis response programs, appropriate housing, and educational supports would produce better outcomes. Analogies were also made to other diseases, for which there is no requirement for a person to accept treatment. It was suggested that a properly informed individual with mental illness should have the same right to refuse treatment.

The Commission remains of the view that a system of leave certificates should be adopted in Nova Scotia. From the comments received on the Discussion Paper, it seems clear that some mental health patients lack insight into the nature of their mental illness and as a consequence refuse treatment following their discharge from a facility and re-entry to the community. These people tend to deteriorate, ultimately resulting in the need for their re-admission as involuntary patients. A system of leave certificates would permit some of these patients to return to the community earlier than would otherwise have been the case and remain there, thereby helping them to re-assume a more normal lifestyle.

While subject to a leave certificate, a patient would be required to comply with certain conditions outlined in a treatment plan, including, if applicable, the use of prescribed medication. The Commission agrees that as a matter of consistency, given that the Nova Scotia mental health system as well as the Discussion Paper support the idea of capable people being able to choose to receive treatment or not, then whether community treatment is effected in relation to a person would depend on his or her consent. In other words, community treatment, as another form of treatment, would be subject to a capable person's right to refuse. Unlike the system in place in Saskatchewan, the use of leave certificates would not proceed without consent, either of a patient or a substitute decision-maker. The patient would therefore have an opportunity to participate in devising the treatment plan which forms the basis of a leave certificate, thereby improving the chance of compliance and therefore of good results.

Generally, the Commission agrees that the criteria for treatment in the community should be consistent with involuntary admission criteria. Community treatment should be considered the least intrusive option available, and it would also only be provided where relevant services are available. As in the case of involuntary admission, community treatment would be subject to review and would be for a defined period of time.

The Commission recommends that leave certificates should be made available in Nova Scotia for certain involuntary patients. In order for a leave certificate to be issued, the patient must be suffering from a mental disorder for which he or she needs continuing treatment or care and supervision while living in the community. The patient must be considered likely, because of the mental disorder, to cause serious harm to self or others, if the patient does not receive continuing treatment or care and supervision while living in the community. A collaborative treatment plan must be developed, to which the patient or the patient's representative consents. The patient must be capable of complying with the leave certificate requirements. The treatment or care and supervision described in the leave certificate must exist in the community and can and will be provided in the community. Similar to a review of involuntary patient status, the conditions which led to the issuance of a leave certificate are subject to review. The duration of a leave certificate should be defined.

The Commission is of the view that adopting a system of leave certificates would not be at the expense of community support initiatives, such as adequate housing for mental health consumers. Rather, a system which allows more patients to receive treatment in the community instead of in a facility should underscore the need for social and community supports.

The Commission recommends:

- Leave certificates should be made available in Nova Scotia for certain involuntary patients.
- In order for a leave certificate to be issued, the patient must be suffering from a mental disorder for which he or she needs continuing treatment or care and supervision while living in the community. The patient must be considered likely, because of the mental disorder, to cause serious harm to self or others, if the patient does not receive continuing treatment or care and supervision while living in the community.
- A collaborative treatment plan must be developed, to which the patient or the patient's representative consents. The patient must be capable of complying with the leave certificate requirements. The treatment or care and supervision described in the leave certificate must exist in the community and can and will be provided in the community.
- Similar to a review of involuntary patient status, the conditions which led to the issuance of a leave certificate are subject to review.
- The duration of a leave certificate should be defined.

C. PATIENTS' PROPERTY AND FINANCES

1. Mental competence to administer one's estate

Issues similar to those raised by the capacity to consent to treatment provisions (Part III.B.1, above) are also raised by the competency sections of the *Hospitals Act*.

a) Competency determination

When should a competency determination be done?

An estate is everything that a person owns. Subsection 53(3) of the *Hospitals Act* requires a declaration of competency to administer one's estate to be made when a person is admitted to a facility. Although the *Act* requires a determination of a person's capacity to consent to treatment to be done within three days of admission, the precise timing of determining one's competency to administer one's estate is not specified.

A potential issue is whether there should be a mandatory assessment, or if a competency determination should be done only if there is concern about a person's competency to manage his or her financial affairs. The majority of Canadian provincial and territorial jurisdictions, including Nova Scotia, provide for a competency assessment upon admission of a person to a psychiatric facility.

The Commission took the view in the Discussion Paper that given the common law presumption of competency in relation to one's estate, the current statute, which requires a competency determination upon a person's admission to a facility, is inconsistent. By eliminating the need for discretion, having an automatic competency determination might prevent certain problems. In some cases, though, it would be an unnecessary intrusion into a patient's private affairs. One way of dealing with the need for competency determinations would be to allow them when a psychiatrist, during the course of completing a capacity assessment, believed there was also a need for an assessment relating to competency to administer one's estate. Consistent with its suggestion in relation to capacity determinations (Part III.B.1), the Commission suggested that a competency determination should take place only when an issue arises about a patient's competency to administer his or her estate.

This issue did not generate much response, though the commentary received was favorable. The Commission affirms its suggestion from the Discussion Paper and recommends that a competency determination should take place only when an issue arises about a patient's competency to administer his or her estate.

The Commission recommends:

- A competency determination should take place only when an issue arises about a patient's competency to administer his or her estate.

b) Factors for competency determination

Should the current factors for determining a person's competency be revised?

The test to determine one's competency to administer one's financial affairs is similar to the test to determine one's capacity to consent to treatment. The factors for determining a person's competency are set out at subsection 52(3) of the *Hospitals Act* and require the psychiatrist to consider:

> *a)* *the nature and degree of the person's condition;*
> *b)* *the complexity of the estate;*
> *c)* *the effect of the condition of the person upon his* [*or her*] *conduct in administering his* [*or her*] *estate; and*
> *d)* *any other circumstances the psychiatrist considers relevant to the estate and the person and his* [*or her*] *condition.*

In the Discussion Paper, the Commission was of the view that the wording of subsection 52(3) is a good combination of specific terms and flexible wording. In particular, it was suggested, clause 52(3)(d), by referring to "any other circumstances," frees the statute from having to identify all other possibly relevant factors that might arise. The Commission suggested that subsection 52(3), which sets out the factors to be considered in determining a person's competency to administer his or her estate, should remain unchanged.

There was little feedback received on this issue, but the comments supported the Commission proposal. The Commission recommends that the factors to be considered in determining a person's competency to administer his or her estate should remain unchanged.

The Commission recommends:

- The factors to be considered in determining a person's competency to administer his or her estate should remain unchanged.

c) Competency assessors

Who should perform competency assessments?

Psychiatrists currently complete competency determinations under the *Hospitals Act*. Using the same justification as it did in relation to capacity assessments (Part III.B.1c, above), the Commission took the position in the Discussion Paper that suitably qualified health care professionals from outside the psychiatric profession should be permitted to perform competency determinations.

As with the discussion concerning capacity determination, comments received tended to support this recommendation in general. However, commentators pointed out that adequate training would be required in order to perform a competency determination and appropriate criteria would have to be identified.

As it did with respect to capacity assessments, the Commission agrees that the issue of training and experience is a significant, but not insurmountable, one when considering who should conduct competency assessments. With the development of appropriate standards, other people could perform this task, not to replace psychiatrists, but to free them, as needed, to tend to other responsibilities. The Commission recommends that in addition to psychiatrists, suitably qualified health care professionals from outside the psychiatric profession should be permitted to perform competency determinations.

The Commission recommends:

- In addition to psychiatrists, suitably qualified health care professionals from outside the psychiatric profession should be permitted to perform competency determinations.

2. Office of Public Trustee

Should the role of the Public Trustee concerning management of patients' estates be revised?

With respect to management of a person's estate, section 59 of the *Hospitals Act* creates a mechanism whereby the Public Trustee, being notified by a hospital to do so, may "assume management" of the estate of a patient who has no guardian, and who is unable to administer his or her own estate. This referral mechanism continues to be the source of much of the Public Trustee's caseload.[174]

The Public Trustee's intervention is not compulsory in relation to property matters. Like any other estate supervisor, the Public Trustee's office is paid a fee. This fee is paid for from estate assets and varies according to the amount managed.[175]

From the Commission's perspective, set out in the Discussion Paper, the Public Trustee's role in the mental health system is a significant one. Concerning the protection of estates, the Commission was concerned that allowing the Public Trustee discretion about whether or not to intervene might mean that some estates of patients in facilities are left without proper supervision. The Commission was also concerned that in an attempt to meet its operating costs, the Office of Public Trustee might choose to intervene only when an estate's value is large enough to meet the costs of the Public Trustee's work. The Commission took the position that involvement of the Public Trustee in relation to the estates of patients in facilities should not be determined merely by finances. Given the important public service provided by the Public Trustee's Office, its value should not be measured only by whether it can meet its expenses. As a result, the Commission suggested that when the estate of a patient in a facility is in need of supervision and no other person is available, intervention by the Public Trustee should be mandatory. Sufficient resources should be allocated to the Public Trustee's Office to enable it to fulfil its important role without worrying about the ability of some estates to pay.

This issue generated little commentary, none of which was critical of the Commission's proposal. The Commission affirms its comments from the Discussion Paper about the significant role of the Public Trustee in relation to patients' estates.

The Commission therefore recommends that when the estate of a patient in a facility is in need of supervision and no other person is available intervention by the Public Trustee should be mandatory. Sufficient resources should be allocated to the Public Trustee's Office to enable it to fulfil its important role without worrying about the ability of some estates to pay.

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[174] According to the Public Trustee's 2000-2001 Annual Report, of the 29 new adults' estates (living), 14 originated from a "Section 59" referral: Nova Scotia, Office of Public Trustee, *Annual Report for Fiscal Year Ending March 31, 2001* (Halifax: The Office, 2001), at 3. It should also be noted that the *Powers of Attorney Act*, R.S.N.S. 1989, c. 352 allows for people to avoid the effect of s. 59 of the *Hospitals Act*, by specifying that the attorney and not the Public Trustee is to conduct the administration of the person's estate.

[175] The fees are based on a scale suggested by the Supreme Court of Nova Scotia: Public Trustee, *Annual Report*, note 174, above, at 7.

The Commission recommends:

- When the estate of a patient in a facility is in need of supervision and no other person is available, intervention by the Public Trustee should be mandatory. Sufficient resources should be allocated to the Public Trustee's Office to enable it to fulfil its important role without worrying about the ability of some estates to pay.

D. REVIEW AND APPEAL

1. Composition of review boards

Should the composition of review boards be defined?

To "review" a decision is to reconsider it. Section 61 of the *Hospitals Act* allows the provincial Cabinet to appoint persons to be members of a review board for one or more facilities. The board is known as the Psychiatric Facilities Review Board. In order for a review board to hold a hearing, section 62 of the *Act* requires a minimum of three members (a "quorum"). Unlike legislation in some other Canadian jurisdictions, the *Hospitals Act* does not define the composition of a review board. By contrast, the British Columbia *Mental Health Act* provides for review boards consisting of a chair, a physician appointed by the treating facility, and a person, other than the patient or a member of the patient's family, who is appointed by the patient.[176] The Nova Scotia *Act* does indicate, however, that no member shall sit on a review board considering the review of a patient, client, or relative of that member. In practice, a review board usually consists of a lawyer, a psychiatrist and another non-lawyer, with the lawyer acting as chair.

In the Discussion Paper, the Commission was of the view that in relation to the composition of a review board, the current wording of the *Act* should remain unchanged. The flexibility of the current review board provisions, it was suggested, would be diminished if the *Act* required every review board to include a representative from a certain group. The Commission was also concerned that to insist upon representatives from certain groups could make the statute more complicated in content and more difficult to apply. For example, it could prove difficult to define what nature and extent of mental health services would be required to qualify someone as a "mental health consumer"[177] for the purpose of serving on the board. The Commission therefore suggested that the composition of a review board need not be defined in the *Act*.

Although the Commission considered flexibility to be a strength in relation to review board composition, the Commission was also aware of the need among review board members for a minimum level of information about the responsibilities involved with their appointments. The Commission referred to its Final Report on reform of the administrative justice system and affirmed the recommendation that training should be provided for all review board appointees.[178] Training would include an introduction to mental health concepts and issues which might likely arise as part of a review board hearing. Training would also include the requirements of natural justice, fairness, human rights law, and modern caseflow management practices.

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[176] Note 103, above, s. 25(5).

[177] A mental health consumer is a person who, because of a mental health problem, uses or at some point used, mental health services: Nova Scotia, Minister of Health, Minister's Action Committee on Health Care Reform, *Achieving Health for All: The Mental Health Component* (N.p.: [Dept. of Health,] 1994) at 44.

This issue did not generate much commentary. One commentator, though supportive of the Commission recommendations, added that the present practice should be maintained of having a lawyer and a psychiatrist serve on a review board. Other commentators proposed that the qualifications for membership on a review board, as well as a job description, which set out the duties of a member, should be identified. It was suggested this would ensure appropriate persons, sympathetic to the interest of mental health consumers, would be selected for membership on a review board. These commentators also suggested that mental health consumer input was required in any training being devised for review board appointees.

Upon further reflection and discussion, the Commission recommends that a sitting review board should consist of a lawyer, a psychiatrist, and a lay person. This is an arrangement which ensures that each review board panel represents not only technical knowledge in medicine and the law, but also a range of perspectives generally.

The Commission affirms its Discussion Paper proposals about the need for the training of review board members. This training will help to ensure that board members are sensitive to the concepts, issues, and practices that will likely form part of the review board process. The Commission therefore recommends that training should be provided for all review board appointees. Training should include an introduction to mental health concepts and issues which might likely arise as part of a review board hearing. Training should also include the requirements of natural justice, fairness, human rights law, and modern caseflow management practices.

The Commission recommends

- A sitting review board should consist of a lawyer, a psychiatrist, and a lay person.
- Training should be provided for all review board appointees. Training should include an introduction to mental health concepts and issues which might likely arise as part of a review board hearing. Training should also include the requirements of natural justice, fairness, human rights law, and modern caseflow management practices.

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[178] Law Reform Commission of Nova Scotia, *Reform of the Administrative Justice System in Nova Scotia*, Final Report (Halifax: The Commission, 1997) at 45.

2. Review applications

a) Applicants

Who can apply for a review hearing?

The main function of a review board is to review the involuntary status of patients detained in psychiatric facilities. Since voluntary patients are not officially detained and are able to leave a facility if they choose, most provincial and territorial mental health statutes do not provide voluntary patients with a right of review.[179]

In Nova Scotia, the list of those who can request a review of a patient's file, and therefore a review hearing, is set out at subsection 65(1) of the *Hospitals Act*:

> *a)* *the patient;*
> *b)* *a person, other than another patient, authorized by the patient to act on his* [*or her*] *behalf;*
> *c)* *the administrator of the facility where the person is a patient;*
> *d)* *the medical director of the facility where the person is a patient;*
> *e)* *the administrator of psychiatric mental health services; or*
> *f)* *the Minister.*

Approaches differ in the rest of Canada as to who can request a review hearing. For example, in Alberta, the patient or a representative may apply to a review board for cancellation of an admission or renewal certificate. In New Brunswick, a person who questions the opinion of the attending psychiatrist concerning a declaration of competence may apply for a review. The Yukon *Mental Health Act* provides that an application for review can be made by "any person having a substantial interest in the subject matter of the review application."[180]

In the Discussion Paper, the Commission was of the view that for the most part, the list at subsection 65(1) of the Nova Scotia statute of those entitled to apply for a review hearing is satisfactory. Although it lacks specificity to some extent, it was suggested, this is compensated in part by its flexibility. The Commission noted that subsection 65(1) does not specifically refer to applications by substitute decision-makers, appointed by a patient to act on the patient's behalf. Nonetheless, clause 65(1)(b), which refers to "a person, other than another patient, authorized by the patient to act on his behalf" should be wide enough, it was suggested, to take substitute decision-makers into account. Consistent with the current mental health system, the Commission pointed out that at clause 65(1)(e), the wording should be changed to take into account the fact there is no "administrator of psychiatric services."

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[179] The Ontario and British Columbia statutes, however, allow for the review of a voluntary patient's admission if that patient was admitted to the facility on the authority of a parent or guardian. According to British Columbia law, a voluntary patient under the age of 16 can apply to the review panel for a review of his or her admission: B.C. statute, note 103, s. 21. In Ontario, the relevant legislation provides for the review of admissions of children between the ages of 12 and 16: Ontario statute, note 94, above, s. 13.

[180] Alberta statute, note 104, above, s. 38; N.B. statute, note 112, above, s. 8.5; Yukon statute, note 110, above, s. 31.

The Commission also noted that some people under the legislated age of majority may be mature enough to understand the nature and consequences of medical treatment. If the parents or guardians of these patients lack initiative or disagree with the need for review, then these patients might be deprived of a review. As a result, the Commission suggested that a patient under the legislated age of majority should also be able to apply for a review.

Commentary received was favorable to the Discussion Paper suggestions, which the Commission affirms. The Commission therefore recommends that for the most part, the list at subsection 65(1) of the *Act* of those who can request a review of a patient's file should remain unchanged. The wording should be amended, though, to take into account the fact that there is no "administrator of psychiatric services." A patient under the legislated age of majority should also be able to apply for a review.

The Commission recommends:

- For the most part, the list at subsection 65(1) of the *Act* of those who can request a review of a patient's file should remain unchanged. The wording should be amended, though, to take into account the fact that there is no "administrator of psychiatric services."
- A patient under the legislated age of majority should also be able to apply for a review.

b) Review board decisions

Should a decision of the review board be binding on the parties?

Section 63 of the *Hospitals Act* sets out what matters can be heard by a review board in Nova Scotia. It includes admission certificates, requirements for psychosurgery, and declarations of capacity and competency. In relation to these issues, a review decision is binding.

A review board is also able to provide recommendations respecting the treatment or care of a patient. These recommendations, however, are not binding on the parties. In some other jurisdictions, such as Prince Edward Island,[181] the orders of review boards are binding on the parties.

Where treatment is in issue, the Commission took the position in the Discussion Paper that the opinion of the treating psychiatrist should be given a great amount of deference. In general, it would not be appropriate for a review board, even one which included a psychiatrist, to substitute its opinion on treatment for that provided by a mental health care professional who was able to take sufficient time to assess a patient and monitor any changes in his or her condition. The Commission was also concerned that if a review board could provide an order about treatment, the review process would become unduly delayed by applications for review. As a result, the Commission suggested that in relation to treatment and care, review boards for the most part should continue to provide only non-binding recommendations. In this way, the review board would continue to have some input into treatment issues, but would generally defer to those who have necessary training and who have spent sufficient time with a patient. A review board would, however, be able to approve compulsory treatment for a person who has not appointed a proxy through an advance health care directive and who has become mentally incapable. A review board would also have to approve extraordinary types of treatment.

This issue generated mixed responses. Some commentators agreed that a review board, for the most part, should continue to provide only non-binding recommendations in relation to treatment and care. For instance, one commentator pointed out that otherwise, for a review board to issue a binding decision about treatment could constitute the practice of medicine without a licence. Another commentator suggested it would not be appropriate for review boards to regulate extraordinary types of treatment, which change over time and which are subject to internal reviews and other supervisory procedures within individual facilities. Other commentators, however, considered the Commission suggestion to pay too much deference to psychiatrists and to not give adequate weight to review board decision-making.

The Commission continues to be of the view that a review board which has spent little time in the company of a patient, and which has only one member with medical training, should only serve an advisory role with respect to decisions involving treatment and care. The Commission also remains of the view that an important exception involves a mentally incapable patient who has not set out his or her wishes beforehand, in an advance health care directive. Consistent with an earlier recommendation, the Commission does not, however, think that the role of statutory substitute decision-makers should be changed. As a result, for a review board to be in a position to make a compulsory treatment decision about a mentally incapable patient, there would have to be no advance health directive in existence, as well as no available statutory substitute decision-maker. Further to an earlier recommendation, the Commission also takes the position that a review board would have to approve extraordinary types of treatment.

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[181] P.E.I. statute, note 101, above, s. 29.

The Commission recommends:

- In relation to treatment and care, review boards for the most part should continue to provide only non-binding recommendations. A review board should, however, be able to approve compulsory treatment for a person who has not made an advance health care directive, who has become mentally incapable, and who has no available statutory substitute decision-maker. A review board would also have to approve extraordinary types of treatment.

3. Limitation on frequency of review applications

Should the current limit on the frequency of review applications be maintained?

Most provinces and territories impose restrictions on the number of times in a given period that a patient may apply for a review hearing. These restrictions usually take the form of limiting the patient to one application for each new admission or renewal certificate. In Nova Scotia, subsection 65(2) of the *Hospitals Act* provides that a review board may refuse a patient's request for a hearing if the patient's file has been reviewed in the previous six months.

The Commission took the position that in the interest of fairness to patients, and consistent with a suggestion earlier in the Discussion Paper, in relation to renewal certificates (Part III. A.5b), the limit on the frequency of review applications should be shortened to three months.

The little commentary that this issue produced was not in favour of the Commission suggestion. One commentator suggested that if the treating psychiatrist can demonstrate to the review board that the patient's condition is chronic and is not likely to change, the frequency of review applications should be not more than once every six months. Another commentator suggested that consistent with the practice in most provinces, there should be one review per admission or renewal certificate.

The Commission continues to think that a limit should be placed on how frequently a patient may apply for a review hearing. Limited resources, both financial and human, make this a necessity. It should not be overlooked that when psychiatrists are preparing for, and appearing before, review boards, they are not providing treatment and care for other patients. A limit also serves to discourage frivolous applications. Further to one of the comments received, the Commission agrees that a reasonable way of proceeding is to tie the frequency of review applications to the duration of certificates which the reviews would involve. The Commission recommends, as prevails in most provinces, that there should be one review per admission or renewal certificate.

The Commission recommends:

- One review application should be permitted during the duration of each admission or renewal certificate.

4. Timing of hearing a review application

Should the current time frames for hearing a review application be maintained?

Subsection 65(1) of the *Hospitals Act* requires a review board to hear a review application within one month of the request. This time frame tends to be longer than the time frames provided by other Canadian mental health statutes. For instance, in Alberta, a review panel must hear a request as soon as it is able to do so and in any case within 21 days. In Ontario, the review board must generally hear the application within seven days of receipt, and in Saskatchewan, a review panel must give its decision within three business days of receiving the application.[182]

In the Discussion Paper, the Commission took note of a concern that if an application for review is not dealt with expeditiously, then ultimately the review process may prove to be of diminished or of no value to some patients. For example, because of undue delays, a patient's admission certificate might expire before a review hearing is held on the issue of that person's involuntary status. A patient might remain longer in a facility than would have been the case had a review board examined the situation. It should not be overlooked that involuntary admission of patients and other *Hospitals Act* decisions involve a significant infringement of people's personal freedom. As a result, the Commission was in favour of shortening the time frame for the hearing of a review application. The Commission also acknowledged, however, that after notice of an application for review is provided, a certain amount of time is necessary in order for the facility to provide copies of documents for the review board, arrange staff schedules, and make other preparations. To accommodate both the need for an expeditious processing of a review application as well as the need for preparation time, the Commission agreed that the approach in Alberta should be put into place in Nova Scotia. As a result, the Commission suggested, a review board should hear a review application as soon as the board is able to do so and in any event, within 21 calendar days of the application being received.

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[182] Alberta statute, note 104, above, s. 40; *Rights and Responsibilities*, note 128, above, at 33; Saskatchewan statute, note 132, above, s. 34.

Few commentators remarked directly on this suggestion. One commentator, estimating that the average length of an involuntary admission stay is about three weeks, suggested that 21 days was a considerable time to wait. This commentator preferred the Ontario standard, which requires an application to be heard within seven days of the application being received. This time period, the commentator pointed out, would itself involve a considerable amount of time for a patient who no longer met the criteria for civil commitment.

The Commission agrees that the Discussion Paper suggestion of 21 calendar days is still too long a period, and that 14 days is a preferable standard. The Commission recognizes that for many people being involuntarily committed can be a difficult experience, and that the review procedure should begin to operate as soon as is reasonably possible. Setting the standard at 14 days represents a considerable reduction, in comparison to the current one month period, but should also allow sufficient time for any administrative arrangements required before a hearing.

The Commission recommends:

- A review board should hear a review application as soon as the board is able to do so and in any event, within 14 calendar days of the application being received.

5. Mandatory reviews

Should the current mandatory review hearings be maintained?

In some Canadian jurisdictions, as for example, in British Columbia,[183] a patient or the patient's representative is required to initiate the review process. It has been pointed out that in certain circumstances, this may be less than satisfactory. A patient may not be aware of his or her rights, or may not be able to assert them. A patient's representative could similarly lack knowledge or an ability to assert a position. There is also the possibility that the efforts of a patient's representative, such as a relative, had led to the patient's commitment. The patient's representative might therefore be reluctant to vigorously assert the patient's rights.

To help redress the situation of a patient unable to assert his or her right to a review, in some provinces, mandatory periodic review of patients' files is required. For example, in Nova Scotia, section 64 of the *Act* requires the review board to review the file of every involuntary patient once every six months for the first two years and then once a year thereafter.

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[183] B.C. statute, note 103, above, s. 25.

In the Discussion Paper, the Commission was of the view that mandatory, periodic reviews of a patient's file are an important safeguard of a patient's rights. Mandatory reviews can help to protect a patient who, because of a lack of knowledge, initiative, or from additional factors, would not otherwise assert his or her right to a file review. Similar factors might affect a patient's representative. The Commission took the position that the average length of time between mandatory reviews should be shortened. As a result, the Commission suggested there should be a mandatory review of a patient's file every six months. The Commission emphasized that a mandatory review, once undertaken, should be completed as expeditiously as possible.

Commentators agreed with the appropriateness of continuing mandatory reviews. However, some commentators suggested that to protect the interest of patients, a mandatory review should occur far more frequently than every six months.

At III.D.3, above, of this Report, the Commission recommended that the frequency of review applications available to a patient or the patient's representative should be tied to the duration of the certificate involved. In other words, the patient or the patient's representative would be able to apply for a review hearing once during the time of each admission or renewal certificate. When considered in conjunction with a recommendation at III.A.5b, that renewal periods would never be longer than three months, this would considerably reduce (from six months to three) the maximum amount of time a patient might have to wait before applying for a review hearing. Consistent with those recommendations and for the reasons mentioned in the Discussion Paper, the Commission affirms its suggestion, that there be a mandatory review every six months. This recommendation is made on the understanding that this would be a complete review with a full oral hearing. The Commission also recommends that once undertaken, a mandatory review should be completed as expeditiously as possible.

The Commission suggests:

- There should be a mandatory review, namely a complete review with a full oral hearing, of a patient's file every six months.
- Once undertaken, a mandatory review should be completed as expeditiously as possible.

6. Procedure at review board hearings

a) Duty to hold a hearing

Should there be a duty for a review board to hold a hearing?

In Nova Scotia, section 66 of the *Hospitals Act* requires a hearing to be held if the review board receives a request for a hearing by any person authorized to do so. It does not, however, specify that an oral hearing is required. In most other Canadian jurisdictions, the review board is required to hold a hearing to consider the application for review. By contrast, in New Brunswick, the review board is under no statutory duty to hold a hearing,[184] though it may hold a hearing for the purpose of receiving oral testimony.

In order to ensure that the review process is fair and open, and to facilitate the presentation of as much relevant information as possible, the Commission took the position in the Discussion Paper that a hearing should be held whenever a review board considers an application for review. This was consistent with a recommendation in the Commission's Final Report on administrative law.

This suggestion produced mixed responses. A number of commentators expressed support for the Commission suggestion. One commentator, having pointed out that in British Columbia, all applications require a hearing except where mandatory reviews are involved, suggested that hearings can detract from other patients' care when psychiatrists are involved at the hearing. Other commentators suggested that the Commission proposal lacked the specificity required to ensure the review board conducts its proceedings in a fair manner.

In its Final Report on administrative law, the Commission supported, as a procedural requirement forming part of the administrative process, the right to be heard of a person whose entitlements or privileges are being affected.[185] In that report, the Commission indicated that an oral hearing allows a person's right to be heard to be put into effect. At a hearing, a person can present witnesses to put forward evidence on his or her behalf. A person can question witnesses who provide evidence to support a contrary position. A hearing also enables a person to be present to answer any questions which the administrative decision-makers might have. Affirming these reasons, as well as its Discussion Paper suggestion, the Commission recommends that a hearing should be held whenever a review board considers an application for review.

At a review hearing, the facility will be the party with the greater resources at its disposal. It will also be seeking in some form to place limits on a patient's personal freedom. For these reasons, the Commission recommends that the onus of proof during a review board hearing should explicitly be borne by the facility. This will make it clear that the burden will rest on a facility to establish the merits of its position. If it is not able to do so, then the patient's position will prevail.

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[184] N.B. statute, note 112, above, s. 32.

[185] Note 178, above, at 49-50.

The Commission suggests:

- A hearing should be held whenever a review board considers an application for review.
- The onus of proof during a review board hearing should explicitly be borne by the facility.

b) Attendance at hearing

Who should be able to attend a review hearing?

When a review hearing is to be held, it must be decided who is entitled to receive notice of the hearing and who can attend. In order to protect the privacy of patients and to ensure that only relevant information is presented to the board, restrictions are placed on who is entitled to attend a hearing. In Nova Scotia, members of the public are excluded from a hearing unless requested to attend by the patient or the patient's representative. Notice of a hearing is to be given to the patient or the patient's representative, to the administrator of the facility where the patient is located, and to any other person who requested a hearing where that person is not otherwise entitled to receive notice.[186] The *Hospitals Act* at subsection 65(5) also expressly provides a patient or the patient's representative with the right to attend a hearing and to be heard.

In the Discussion Paper, the Commission preferred the flexibility associated with a general provision relating to people entitled to attend a hearing. A general provision, it was suggested, can accommodate the variety of situations and relationships which could lead to a person or institution having a legitimate interest in a review application. The Commission was of the view it would be too difficult to attempt to predict all people who might have such a legitimate interest. As a result, the Commission suggested that the *Act* should define in a general fashion who may attend a review hearing. The review board, it was suggested, should have the discretion to determine whether or not a person has the necessary or legitimate interest in order to attend. The patient and the relevant facility would receive automatic notice.

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[186] *Hospitals Act*, note 50, above, ss. 66(3), 66(8).

To help protect the interests of minors, the Commission also suggested that when a review hearing will involve a minor, notice should be sent not only to the minor, but also to the minor's parents or guardian.

For the most part, commentators seemed supportive of the Commission suggestions, though they also proposed certain additional details in this context. One commentator suggested that the facility should have an opportunity to suggest if other people should attend with the patient. It was also suggested, given that community treatment orders, if available, will have an impact on family members, it may be advisable to provide notice to a patient's parents. Another commentator proposed that a patient's near relatives should be informed of the patient's application to the review board, just as they are informed in most of the country of the patient's admission to a facility. Once family members receive this information, then they would have to approach the review board and request to present evidence. In other words, family members would not have the right in general to attend the hearing, but would be treated like other witnesses.

The Commission agrees that family members should not be entitled as of right to attend a review hearing. Although some family members may wish to attend a hearing to provide information which they believe would be of assistance to a patient, other relatives may not have a patient's best interest at heart. In the Commission's perspective, this is another reason to define in general fashion who is entitled to attend a review hearing, with the review board having the discretion to decide on necessary or legitimate interest. The Commission therefore affirms its Discussion Paper suggestion that the *Hospitals Act* should define in a general fashion who is entitled to attend a review hearing. The review board should have the discretion to determine whether or not a person has the necessary or legitimate interest in order to attend.

The Commission also agrees that in addition to the patient and the relevant facility, the patient's representative, if one is available, should also receive notice of a hearing. When a review hearing will involve a minor, notice should be sent not only to the minor, but also to the minor's parents or guardian.

The Commission recommends:

- The *Hospitals Act* should define in a general fashion who is entitled to attend a review hearing. The review board should have the discretion to determine whether or not a person has the necessary or legitimate interest in order to attend.
- The patient, the relevant facility, and, if available, the patient's representative, should automatically receive notice of a hearing.
- When a review hearing will involve a minor, notice should be sent not only to the minor, but also to the minor's parents or guardian.

c) Protection against bias

Should a review board member sit on a review hearing if he or she has taken part in a previous hearing involving the same patient?

In Ontario, members of a review board are not entitled to take part in a hearing if they have already been involved in any investigation or consideration of the hearing's subject-matter. In *Dayday* v. *MacEwan*, the court explained that the purpose of the Ontario rule was to ensure "each review board panel holding a hearing approach the issues before it free of any influence by reason of prior involvement by any of its members in the same patient's case."[187]

The Commission pointed out that its suggestions elsewhere in the Discussion Paper, if adopted, would mean a system where frequent reviews involving the same patient are possible. In order to prevent a board member from sitting on a review board, if that member has already participated in a hearing involving the same patient, would require a large pool of review board members. The Commission was concerned there may not be sufficient numbers of review board candidates with the required knowledge, experience, and interest. This would particularly be the case for psychiatrists, most of whom work in the Halifax Regional Municipality. In other parts of the province, it was suggested, there may not be sufficient psychiatrists to satisfy a rule preventing previous participation by a review board member in a hearing involving the same patient.

The Commission took the position in the Discussion Paper that having experienced review board members would help to ensure an effective review process. Allowing board members to participate in more than one hearing involving the same patient would contribute to an experienced board. The Commission also took the view that given the qualifications of board members, one must have confidence in their abilities, including the ability to excuse themselves from a hearing on the ground of a potential conflict. Without such confidence, the review system would be founded on a suspect board. As a result, the Commission suggested, the law should not prevent a review board member from participating in a hearing if he or she has already taken part in a hearing concerning the same patient. The Commission agreed with the wording of subsection 62(3), which prevents a review board member from participating in the review of a patient, client, or relative of the review board member. This provision helps to ensure that certain close relationships with a patient do not adversely influence a board member's decision, or lead to the impression that such influence exists.

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[187] (1987), 62 O.R. (2d) 588 at 593 (Dist. Ct.). See also *Young* v. *Houtman* (1990), 45 Admin. L.R. 30 (Ont. Dist. Ct.).

The little commentary received in relation to this issue was favorable to the Discussion Paper suggestions, which the Commission affirms. The Commission therefore recommends that the law should not prevent a review board member from participating in a hearing if he or she has already taken part in a hearing concerning the same patient. The Commission also recommends that the wording of the current *Act* at subsection 62(3), which prevents a review board member from participating in the review of a patient, client or relative of that review board member, should remain unchanged.

The Commission recommends:

- The *Hospitals Act* should not prevent a review board member from participating in a hearing if he or she has already taken part in a hearing concerning the same patient.
- The wording of the current *Act* at subsection 62(3), which prevents a review board member from participating in the review of a patient, client, or relative of that review board member, should remain unchanged.

d) Duty to provide written reasons

Should written reasons be included in review board decisions? Should the current time frames be maintained?

In Nova Scotia, section 67 of the *Act* requires a review board to provide a written decision to the parties within 14 days of a hearing. The *Act* does not, however, require written reasons. Review boards have a statutory obligation, though, to provide written reasons for their decisions in Alberta, Manitoba, Ontario, and Yukon.[188] The Nova Scotia Supreme Court has suggested that as a matter of policy, the Nova Scotia review board purposely did not give reasons for fear of causing more harm to some patients.[189]

In *Future Inns Canada Inc.* v. *Labour Relations Board (NS)*,[190] the Nova Scotia Court of Appeal provided some guidance on the issue of whether or not review tribunals should give reasons for their decisions. The court indicated that reasons are not always necessary and gave the example of a finding clearly supported by the evidence. The court went on to explain that a tribunal should provide written reasons "wherever there are substantial issues to be resolved." When reviewing a tribunal's decision, it was important for a court to be able to decide whether or not the tribunal had a rational basis for its decision. If the reasonableness of a tribunal's decision could only be determined by examining the reasons which underlie a decision, and those reasons were not obvious from a review of the issues and the record of the proceedings, written reasons would be necessary. The Commission's Final Report on administrative law, which was referred to in the *Future Inns* decision, recommended that administrative decision-makers should provide reasons for their decisions.[191]

To help protect patients' rights and to achieve clarity and openness in the review process, the Commission, in the Discussion Paper, was of the view that review boards should provide written reasons for their decisions. To attempt to achieve a balance between promoting expediency within the review system and allowing review board members adequate time to consider all the evidence, the Commission suggested that a decision should be communicated to the parties involved as soon as possible, and in any event, within 14 calendar days of the hearing.

All commentators who remarked on this issue agreed that a review board should provide written reasons for a decision. One commentator suggested that the proposed 14 day period for communication of the reasons was too long. It was suggested this meant uncertainty, not just for a patient, but also for treating staff and others, which would be counter-productive to treatment and discharging the patient from a facility. Other commentators suggested that a maximum of five days should be available for the board to reach and communicate its decision. These commentators added that the legislation should be explicit concerning the minimum content of any decision.

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[188] Alberta statute, note 104, above, s. 41(4) [applies when there is a decision not to cancel admission or renewal certificates]; Manitoba statute, note 129, above, s. 56; *Rights and Responsibilities*, note 128, above, at 34 [applies when a request for reasons is received from any of the parties within 30 days of the hearing date]; Yukon statute, note 110, above, s. 36.

[189] *MacNeil*, note 76, above, at 20.

[190] (1997), 160 N.S.R. (2d) 241 at 253.

[191] Note 178, above, at 55.

The Commission affirms its Discussion Paper suggestion that review boards should provide written reasons for their decisions. Reasons would be provided at the same time as a decision. After taking into account comments received and upon additional discussions, the Commission agrees that its suggestion for improving the speed with which review board decisions are provided did not go far enough. The Commission recommends instead that a review board decision should be communicated within five days of the hearing. The Commission takes the position that the statute should make clear the consequences of a review board's failure to provide a written decision in a timely fashion. As a result, the Commission also recommends that if a review board decision is not provided within the allotted time frame, then the patient should be automatically discharged.

The Commission recommends:

- Review boards should provide written reasons with their decisions.
- A decision with reasons should be communicated to the parties involved as soon as possible, and in any event, within five calendar days of the hearing.
- If a review board decision is not provided within five calendar days, then the patient should be automatically discharged.

e) Patient as a compellable witness

Should the review board be able to compel the appearance of a patient at a hearing?

Subsection 66(6) of the *Hospitals Act* allows a review board to require a patient's appearance at a hearing. By contrast, the Newfoundland *Mental Health Act* states that a patient's attendance at a hearing is not required.[192] The legislation in many of the other provincial and territorial jurisdictions is silent on this issue.

In the Discussion Paper, the Commission suggested that though a patient should be given the opportunity to attend and be heard at a review board hearing, it goes too far to require a patient's attendance. Subsection 66(6) of the *Hospitals Act* may have been motivated by a desire to ensure that a patient's point of view is represented. This need is, however, taken care of in other ways. In particular, subsection 66(5) allows both a patient and if applicable, the patient's representative the right to be present at a hearing involving the patient and to be heard. The Commission noted that section 7 of the *Charter* has been held to guarantee a right to silence in certain circumstances. In particular, a person whose freedom is being placed in question by judicial process must be given the choice of whether or not to speak to the authorities.[193] The Commission suggested that subsection 66(6), which permits a review board to require a patient's appearance at a hearing, should be deleted.

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[192] Note 94, above, s. 17.

This issue did not produce much commentary. One commentator suggested that as long as the board has access to the patient's file and other witnesses, then a patient's compellability would not be an issue. However, it was suggested that a failure by a patient to appear might mean the board is faced with a lack of evidence. Another commentator, though agreeing with the Commission suggestion, stated that the review board should invite and encourage the patient to appear. It was suggested that the patient should receive in writing an invitation to appear, and that the patient should be allowed to change his or her mind at the last minute.

Compulsory attendance might be found to contravene the right to security of the person which s. 7 of the *Charter* provides. This issue has yet to be decided by the courts.[194] In any event, requiring the patient's attendance does not convey the proper message about review hearings. It might contribute to the impression that review hearings are a difficult and adversarial experience; otherwise, people would not be forced to attend. Although agreeing that as far as possible patients should participate in decisions relating to their mental health treatment and care, the Commission is not of the view that this participation should be forced. As a result, though not taking the position that a patient should be required to attend a review hearing, the Commission recommends that the board should nonetheless encourage a patient's participation.

The Commission recommends:

- The review board should not be empowered to require a patient's appearance at a hearing. The review board should, however, encourage a patient's appearance.

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[193] See *R.* v. *Hebert*, [1990] 2 S.C.R. 151.

[194] In *C.W.* v. *Manitoba (Mental Health Review Board)* (1992), 84 Man. R. (2d) 33 (Man. Q.B.) it was held contrary to the principles of justice (*Charter* s.7) and therefore unconstitutional to require a patient to testify at his or her own review board hearing. On appeal [(1994), 95 Man. R. (2d) 152 [Man. C.A.)], however, that decision was overturned, as the trial judge did not have the proper factual background on which to decide an issue pertaining to the *Charter*.

7. Mandatory legal representation

Should there be mandatory legal representation for patients at review board hearings?

A facility in Nova Scotia is required to provide assistance to any patient or person under observation who wishes to contact a lawyer.[195] The Nova Scotia statute does not provide for mandatory legal representation. By contrast, the *Uniform Mental Health Act* indicates that in a proceeding before a review board or on an appeal therefrom in respect of an involuntary patient of a psychiatric facility, the patient shall be deemed to have capacity to instruct a lawyer, and if the patient does not have legal representation, the review board or the court, as the case may be, may direct that legal representation be provided for him or her.[196]

In its Final Report on adult guardianship, the Commission proposed that an adult subject to a guardianship application should have a right to be represented by a lawyer, but that it should not be mandatory that a lawyer be provided.[197]

In the Discussion Paper, the Commission acknowledged that an ideal system would provide legal representation at no charge to patients. Given the current financial situation and competing demands on provincial resources, it was suggested, a system of mandatory legal representation may not, however, be realistic. Alternatives to Legal Aid could involve legal representation being provided for patients by the Public Trustee Office or by the mental health facility to which a patient has been admitted. Once again, though, a lack of resources would likely be a problem. In relation to a facility, there might also be a concern about the lack of independence of a legal representative who is affiliated with a particular facility. The Commission invited comments on whether or not patients should be entitled to mandatory legal representation at a review board hearing, and if so, how this could best be provided.

The Commission's invitation for comments generated a wide range of perspectives. For example, one commentator suggested that patients should not be entitled to mandatory legal representation, but should be advised they have a right to legal representation. Another commentator indicated that if an absence of lawyers in review board hearings demonstrably results in a violation of patients' rights, then the resources should be found to provide mandatory legal representation. If not, this commentator suggested, other protections, such as the appeal process and access to advocacy services, would have to suffice. This commentator added that it would be difficult for lawyers associated with a particular facility to represent a patient without the appearance of bias, as the interests of a facility and those of a patient may not be similar. Other commentators suggested that mandatory legal representation would have positive benefits for mental health consumers and mental health service utilization rates.

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[195] *Hospitals Act*, note 50, above, s. 70(8). A recent report suggested that access by involuntary patients in Nova Scotia seems to be problematic at times. See Nova Scotia, Department of Health, *Mental Health: A Time for Action* ([Halifax: The Department], 2000) online: N.S. Dept. of Health Web site <http://www.gov.ns.ca/health/> (date accessed: 3 December 2001) at 27.

[196] Note 96, above, s. 38.

[197] Note 167, above, at 24.

The Commission recognizes the value of legal representation generally. It acknowledges the vulnerability of certain patients and encourages the provision of Legal Aid in the context of a review board representation. Nonetheless, for the reasons provided in the Discussion Paper, the Commission does not recommend that there be mandatory legal representation for patients at review board hearings.

The Commission recommends:

- Mandatory legal representation is not required for patients at a review board hearing.

8. Right to advocacy services

Should a right to advocacy services be included?

An advocate is someone who provides support and speaks on behalf of another. Advocates are often lawyers, but it is not necessary for an advocate to have legal training. The *Hospitals Act* does not require advocacy services to be provided to patients. Subsection 70(8) requires that the facility provide both patients and persons under observation with advice on their right to legal counsel, as well as providing assistance with contacting a lawyer. Subsection 66(7) also provides that a review board may appoint a representative to act on behalf of a patient. The Uniform Law Conference of Canada has recommended that "patient advisors" be available for patients involuntarily detained in psychiatric facilities.[198]

Being admitted to a psychiatric facility can be a frightening and bewildering experience. In the Discussion Paper, the Commission expressed the view that it could help put at ease those people who enter a facility if they can speak with a empathetic and knowledgeable person about what admission entails and the nature of their rights. Advice on the nature of one's rights could be important in relation to such matters as the review of a person's involuntary patient status, treatment decisions, management of finances, and access to health information.[199] In

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[198] Note 96, above, s. 20.

[199] A recent report on mental health services in Nova Scotia commented that it was "imperative" for involuntary patients to be well-informed of their rights: see note 195, above, at 27.

Ontario, a person fulfilling this role at a facility is known as a "rights adviser." A rights adviser is entrusted with the responsibility of explaining a matter pertaining to rights to the best of his or her ability in a manner that addresses the special needs of the person receiving the explanation.[200]

In the Discussion Paper, the Commission acknowledged that given declining health care budgets, especially in the instance of smaller facilities, it may be difficult to justify employing someone solely as a rights adviser. The Commission noted, however, that in Ontario, rights advisers can fulfil other duties at a facility. A rights adviser is not someone involved in the direct clinical care of a patient to whom the rights advice is to be given. A rights adviser must be knowledgeable about rights of application to a review board, the nature and procedures of the review board, and how to obtain legal services. A rights adviser must also have effective communication skills.[201] The Commission suggested that the *Act* should provide for a rights adviser at each psychiatric facility, with a similar role and qualifications to those in Ontario.

Most comments received expressed the view that rights advisers at each psychiatric facility are not required. Some commentators took the position that though that idea of rights advisers was appropriate generally, this position should not be restricted to psychiatric facilities. It was pointed out that issues such as capacity or competency assessments, adherence to an informed consent process, the use of advance health care directives, and the initiation of emergency treatment are some of the issues not limited to mental health patients. It was also suggested that rather than creating the position of rights adviser, appropriately trained nursing staff could fill this role. Other commentators, however, thought that rights advisers were necessary, not only to provide advice on rights, but to help patients to actually act upon the advice given, in order to attain what the patient wants to achieve.

The Commission continues to agree upon the potential benefits of rights advisers at a psychiatric facility. A rights adviser can help to make a person's stay at a facility less difficult, stressful, and even frightening. If financial resources might be a problem, then the Commission is of the view that rights advice can be made part of the responsibilities of existing staff. The Commission notes that the current *Act* obliges facilities to provide advice on rights. In addition to the requirement that a facility post in written form information about certain patient rights, subsection 70(8) obliges a facility to provide assistance to the following patients or persons under observation: those who are unable to read or understand and who wish an oral explanation of any document or written communication; those who wish to contact a lawyer; or those who wish to apply for review by a review board. Providing for rights advisers would therefore be formalizing arrangements which facilities should already have undertaken.

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[200] R.R.O. 1990, reg. 741, s.16.

[201] Ontario statute, note 94, above, ss. 1(1-2); note 200, above, s. 14. A rights adviser must also not be someone who provides treatment or care and supervision under a community treatment plan.

The Commission affirms its Discussion Paper suggestions on this issue and recommends that the *Act* should provide for a rights adviser at each psychiatric facility. A rights adviser would be entrusted with the responsibility of explaining a matter pertaining to rights to the best of his or her ability in a manner that addresses the special needs of the person receiving the explanation. A rights adviser should be knowledgeable about rights of application to a review board, the nature and procedures of the review boards, and how to obtain legal services. A rights adviser would also require effective communication skills.

The Commission recommends:

- The *Act* should provide for a rights adviser at each psychiatric facility.
- A rights adviser would be entrusted with the responsibility of explaining a matter pertaining to rights to the best of his or her ability in a manner that addresses the special needs of the person receiving the explanation.
- A rights adviser should be knowledgeable about rights of application to a review board, the nature and procedures of the review boards, and how to obtain legal services. A rights adviser would also require effective communication skills.

E. CONFIDENTIALITY OF PERSONAL HEALTH INFORMATION

The mental health legislation of most Canadian provinces and territories includes provisions concerning accessibility, disclosure, and use of personal health information. Personal health information is gathered to facilitate the effective treatment of a patient during his or her hospitalization and in some cases, after the patient has been discharged. In general, health care professionals are obliged to keep information about their patients confidential. The understanding that private patient information will not be disclosed provides a foundation of trust to the relationship between patient and health care professional. Moreover, given the social stigma often associated with mental illness, as well as the possible vulnerability of persons with mental illness, there is a particular need to keep all mental health records confidential, unless consent for their disclosure is given by the patient or the patient's substitute decision maker, or is otherwise authorized by law.

Relevant legislation in Canada has tended to focus on health care professionals in a variety of settings. What sometimes result are varying standards of confidentiality, with both regulatory overlap and gaps.[202] The variety of legislative responses, combined with the increasing use of health information computer data bases, have created interest in some provinces for improved legislation to strengthen and standardize confidentiality requirements among health care professionals. Manitoba created such legislation in 1997,[203] and in 1999, both Alberta and Saskatchewan enacted equivalent statutes.[204] The Canadian Medical Association has also developed a *Health Information Privacy Code* to assist physicians in their decisions about how personal health information should be collected, used and disclosed.[205]

Issues concerning the confidentiality of personal health information are complex and numerous. They include, among other things, identification and definition of different types of health information; ownership of health records; collection of health information; access, disclosure, and use of personal health information; integrity and security of health information; accountability of record keepers; and interaction of privacy legislation with health information.

This Final Report is limited to the following issues related to personal health information: use, accessibility and disclosure of health records; accuracy, correction and amendment of health records; and implications for the interaction of privacy legislation with personal health records.[206] Moreover, though the nature of the legislation and case law requires the Commission to refer generally to patients and health care records, any recommendations made by the Commission in this section are made in relation to the mental health context alone.

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[202] D. Ferguson, "Overview of Current Law Relating to the Confidentiality of Health Care Information - What Have We Learned from Past Experience?" (1990) 10:3 Health L. Can. 200 at 202.

[203] *Personal Health Information Act*, S.M. 1997, c. 51.

[204] *Health Information Act*, S.A. 1999, c. H-4.8; *Health Information Protection Act*, S.S. 1999, c. H-0.021.

[205] Canadian Medical Association (CMA), *CMA Health Information Privacy Code*, online: CMA Web site <http://www.cma.ca/cma/common/displayPage.do?pageId=/staticContent/HTML/NO/12/where_we_stand/1998/09-16.htm> (date accessed: 3 December 2001).

1. Use, accessibility and disclosure of health records

It was only recently established that patients have a legal right of access to their own health records, subject to limited exceptions.[207]

From a patient perspective, it has been suggested that the right of full access to one's health record is essential for a number of reasons:[208]

- this information is required by the patient in order to make informed decisions regarding his or her health care;
- as health information is frequently disclosed to third parties, patients should be aware of what information is in their own records;
- access to health records fosters patient involvement in health care; and
- accuracy of the health records is facilitated by patients' access to their records.

a) Statutory right of access

Should a patient or a patient's representative have a statutory right of access to the patient's health records, including a right to examine and to copy the records?

In *McInerney* v. *MacDonald*, the Supreme Court of Canada held that at common law patients have a general right of access to their own medical records. This right arises from the "fiduciary" nature of the physician-patient relationship.[209] A fiduciary relationship is one of special trust and confidence. By sharing information during the course of medical consultation, a patient is treated by the law as having entrusted this information to the physician. The patient's right of access to his or her health record, however, is not absolute. The Supreme Court acknowledged that a physician with a reasonable belief it is not in a patient's best interests to inspect his or her medical records has discretion to deny access. This discretion must be exercised on proper principles and not in an arbitrary fashion.

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[206] Given the number and nature of issues involved, the subject of personal health information could form the basis of a separate Commission project.

[207] *McInerney v. MacDonald* (1992), 93 D.L.R. (4th) 415 (S.C.C.) [hereinafter *McInerney v. MacDonald*]. Arguments that disclosure of records would lead to unfounded lawsuits, that patients would not understand records, that health care professionals would be deterred from keeping complete and frank records, and that access could be harmful to patients were not accepted by the court.

[208] See H. Hobart, *A Legislative Proposal Addressing the Access to and Disclosure of Health Information* (LL.M. Thesis, Dalhousie University, 1995) [unpublished] at 43-45; S. Malcolmson, "Access by Patients to the Clinical Record" (1992) 13:2 Health L. Can. 160.

[209] *McInerney* v. *MacDonald*, note 207, above, at 427.

The common law is reflected in varying degrees in Canadian mental health statutes and related legislation. In Nova Scotia, the *Hospitals Act* does not explicitly permit a patient to examine his or her record. Subsection 71(1) does provide, however, that a hospital record shall not be made available to any person or agency without the consent or authorization of the person or patient who is the subject of the record. A hospital is able to withhold information where this would be in the patient's best interest. If the hospital refuses to make information available, then the person requesting the records can apply to court for a determination whether and to what extent the records shall be made available.[210]

In the event of a dispute over access to records, patients may be reluctant to seek a court order, because of financial concerns, time constraints, or the potential for personal health information to be disclosed during a court proceeding.[211] Additionally, patients may not want to be perceived as troublemakers.

In contrast to Nova Scotia, the legislation in a number of provinces and territories requires a facility to take the initiative if it wishes to prevent disclosure. Prince Edward Island, New Brunswick, Ontario, Manitoba, Yukon, Nunavut, and the Northwest Territories have similar statutory schemes, seemingly based on the *Uniform Mental Health Act*. Under all of these statutes, patients have the right to examine and copy their own clinical record. If the facility wishes to deny a patient access, it must apply to the relevant review board for authority to withhold all or part of the clinical record. The review board must order disclosure unless it holds the opinion this is likely to result in serious harm to the treatment or recovery of the person or is likely to result in serious physical or emotional harm to another person.[212]

In the Discussion Paper, the Commission stated that to promote fairness, openness, and confidence in the mental health care system, as far as possible patients should have access to their health records. Consistent with these aims, the Commission suggested that if a facility wishes to deny a patient access to his or her record, either in whole or part, then the *Hospitals*

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[210] *Hospitals Act*, note 50, above, ss. 71(3-4).

[211] Robertson, note 2, above, at 451-452.

[212] Note 96, above, s. 29; P.E.I. statute, note 101, s. 31; New Brunswick statute, note 112, above, s. 16.1; Ontario statute, note 94, above, s. 36; Man. statute, note 129, above, s. 34; Yukon statute, note 110, above, s. 43; N.W.T. statute (adopted in Nunavut), note 110, above, ss. 49.1, 49.2. In B.C. and Newfoundland, there is no reference to health records in their respective mental health and related statutes.

Act should require the facility to apply for a review board hearing, at which the facility would have to establish why denial of access would be reasonable.

The Commission noted in the Discussion Paper it would make little sense to have a hearing on restriction of access if the facility was required to discuss openly, and therefore reveal to a patient, the nature of the information which the facility wished to keep confidential. As a result, it was suggested, review boards would have to develop procedures whereby the information at issue could be brought to the review board's attention and referred to without being revealed to a patient. The Commission pointed out, for example, that similar procedures are sometimes needed during the course of sexual assault trials, when the admissibility of details concerning a complainant's sexual history is in issue. The Commission acknowledged this is a difficult issue, which involves conflicting values. The patient's right to have access to all information available to a decision-maker is in conflict with the need to prevent the disclosure of details which could prove harmful. In this context, the Commission asked for comments about what mechanisms and procedures should be adopted to accommodate both the need for openness and the need to keep certain details confidential.

All commentators agreed in general with the patient's statutory right of access to his or her records. Some concerns were expressed, however, about confidentiality, in particular concerning details about third parties. For example, one commentator suggested that a patient should not be permitted to attend a hearing concerning a denial of access to records. Although a patient should be able to appoint a representative to act on his or her behalf, it was further suggested, the representative would have to be bound to maintain confidentiality of the record in cases where the review board ultimately decided to deny access on the patient's part. Other commentators indicated that the need for openness to benefit a patient needs to be balanced by the fact that some information in a patient's health record may be about a third party, such as a family member, whose need for privacy must be protected.

Ordinarily, a patient is entitled to access all information in his or her health record, and in particular details that are to be brought before a review board. The Commission agrees with this general principle. To underscore the need in general for openness, as well as to acknowledge the greater resources enjoyed by a facility in comparison to patients, the Commission affirms its Discussion Paper suggestion concerning the onus of proof in a dispute involving access to details in a patient's health record. The Commission recommends that if a facility wishes to deny a patient access to his or her health record, either in whole or part, then the *Hospitals Act* should require the facility to apply for a review board hearing, at which the facility would have to convince the board why denial of access would be reasonable.

On the other hand, a health record may contain certain details that for reasons of privacy or personal safety, should not be viewed by a patient. These competing interests, namely a patient's right to access and the protection of confidentiality in some contexts, resulted in considerable discussion by the Commission. A personal representative, rather than a patient, could attend a hearing on the access question, but the difficulty which can arise is how to ensure the personal representative preserves the confidentiality of the information discussed. For example, to ensure preservation of confidentiality, it would be necessary for the personal representative not to speak to a patient. This could be problematic, in that the patient would be subject to the review board's decision without having access to all available evidence. The Commission discussed, but did not approve, such possibilities as providing the review board with discretion about who could attend a hearing on denial of access and the possibility of editing certain records before copies are passed on to a patient. Instead, the Commission recommends that as an objective third party with experience representing the interests of individual members of the public, the Public Trustee could be called upon to ensure that a patient's interests are protected at a hearing involving the possible denial of access to health information. In this way, the interests of both patients and third parties would be upheld, and would not be subject to any subsequent restrictions on a personal representative.

The Commission recommends:

- If a facility wishes to deny a patient access to his or her health record, either in whole or part, then the *Hospitals Act* should require the facility to apply for a review board hearing, at which the facility would have to convince the board why denial of access would be reasonable.
- The Public Trustee, as an objective third party, could be called upon to ensure that a patient's interests are protected at a hearing involving the possible denial of access to health information.

b) Use and disclosure

Should there be limits on the use and disclosure of a patient's health information?

Section 71 of the *Hospitals Act* sets out guidelines concerning the confidentiality and disclosure of health information. Section 71 is similar to provisions in the relevant legislation of other Canadian provinces and territories. It specifies that the records and hospital particulars relating to a patient or former patient are confidential and are not to be made available to others without the consent of the patient or someone else on the patient's behalf, namely a guardian, spouse, or common law partner, next of kin, or the Public Trustee.

Health care professionals might assume that a person has implicitly consented for his or her health information to be released to immediate family members and loved ones. A patient, however, may have compelling reasons for insisting on strict confidentiality. These could include shame, a fear of adverse reactions from family members and loved ones, or a desire to shield family members and loved ones from undue worry.[213] Subsection 71(7), to a limited extent, addresses potential concerns of third parties. It allows a hospital or qualified medical practitioner to disclose "general information on the condition of a person or patient unless that person or patient directs otherwise." The Manitoba *Personal Health Information Act*,[214] at section 23, is more detailed. As long as not contrary to the express request of a health care facility patient or resident, or that person's representative, the keeper of health records may disclose to anyone certain specified details about the patient or resident. A person's name, general health status, and location may be revealed. Location is not to be disclosed, though, where this would reveal specific information about a person's physical or mental condition. More generally, personal health information is not to be revealed if the keeper of the records has reason to believe that disclosure might lead to physical or mental harm of the subject of the personal health information.

For the protection of personal privacy, in the Discussion Paper the Commission supported the current Nova Scotia approach, that access to a person's mental health record should in general only be permitted with a person's consent. The Commission generally agreed with how this issue has been dealt with in the *Hospitals Act*, including the specified exceptions. To accommodate the widest range of perspectives possible, the Commission suggested that subsection 71(7), which allows for the disclosure of general information on the condition of a person or patient, unless that person or patient objects, should be retained. This provision, it was suggested, allows a person or patient to set limits on who is entitled to receive certain general details concerning the individual's health. If, however, a person or patient chooses not to mention the matter, then family members and other concerned people could have access to basic details in order to lessen their potential worries. The Commission was not of the view that subsection 71(7) should attempt to list all the types of people entitled to general information, as a potentially large and unforeseeable number could be involved.

These suggestions produced a number of concerns among the commentators. One comment was that mental health information should not be treated as a special category. Another remark was that the Commission suggestion concerning access was too restrictive and might result in unsafe or damaging care, because health care providers or others involved in care, such as family members, do not have the appropriate information. Another commentator wished to ensure that the Commission suggestion was consistent with the requirement of informed consent.

The Commission agrees that mental health information should be treated in the same manner as other health information. This is accomplished by the current version of the *Hospitals Act*, which treats all health information in a uniform fashion. The Commission remains of the view that subsection 71(7) of the *Hospitals Act* is a useful one in its current form and should not be changed. This section upholds the confidentiality of specific details in a person's health record. It is only general information that may be disclosed further to subsection 71(7), and even these details will not be revealed if the person who is the subject of the record objects. As a result, subsection 71(7) represents a balance between protecting a person's right to privacy and allowing family members and others concerned about a person's well-being to obtain basic details which will allow them to provide a person with assistance and support, as well as to eliminate possible worries about a person's safety. The Commission recommends that access to a person's mental health record should in general only be permitted with a person's consent. Subsection 71(7) of the *Hospitals Act*, which allows for the disclosure of general information on the condition of a person or patient unless that person or patient objects, should be retained. Wishing to preserve the flexibility of subsection 71(7), the Commission also recommends there is no need to attempt to list all the types of people entitled to general information about a person or patient at a facility.

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[213] See S. Freedman, "Medical Privilege" (1954) 32 Can. Bar Rev. 1 at 16 for further discussion on the relationship between health care professionals and patients concerning implied consent to disclosure of patient health information.

[214] Note 203, above.

The Commission recommends:

- Access to a person's mental health record should in general only be permitted with a person's consent. Subsection 71(7) of the *Hospitals Act*, which allows for the disclosure of general information on the condition of a person or patient unless that person or patient objects, should be retained.

- There is no need to attempt to list all the types of people entitled to general information about a person or patient at a facility.

c) Should there be limited disclosure to other non-medical agencies or facilities?

Subsection 71(6) of the *Hospitals Act* permits the transfer of patient information between hospitals. Nothing is said about providing necessary information to non-medical agencies or facilities with which a patient could have involvement.

One example might be a patient entrusted to law enforcement or corrections officials, for the purpose of a transfer between facilities. In 1996, a 26 year-old person died at the Nova Scotia Hospital. At the time of his death, this person was the subject of an order of the Provincial Court at New Glasgow requiring him to enter the Forensic Unit of the Nova Scotia Hospital in Dartmouth for a psychiatric assessment. The fatality inquiry concerning the person's death found that the transfer of information about him from the Aberdeen Hospital in New Glasgow and its medical staff through peace officers and sheriffs to the Nova Scotia Hospital was "woefully lacking." The Inquiry Report recommended that "[t]he Joint Committee on

Forensic Services develop a protocol to facilitate the transfer of information [such as] ... the circumstances which led to the arrest of the individual, known persons or institutions providing care or treatment, known diagnosis (provisional or otherwise), allergies and medications...."[215]

Another concern raised relates not to protection of a patient, either in terms of privacy or health, but to protection of third parties. If a patient is considered to be a threat to others, then leaving that person in the care of a non-medical establishment without indicating the patient's potential for dangerousness could subject others to the risk of harm.

In Manitoba, for instance, personal health information may be disclosed to any person if the keeper of the record reasonably believes that disclosure is necessary to prevent or lessen a serious and immediate threat to the mental or physical health or the safety of the individual the information is about, another individual, or public health or safety.[216]

In the Discussion Paper, the Commission took the view that in this context, risks, not only to a patient but as a result of a patient, should be made known to officials at a non-medical establishment to which a patient is being transferred. To prevent risks, the relevant portion of a patient's health care record should be transferred along with a patient. The Commission took the position that a provision equivalent to that from the Manitoba statute would address the need to transfer information concerning a patient in certain appropriate situations. As a result, the Commission suggested, in Nova Scotia, the disclosure of the relevant portion of the patient's health care record should be possible to any person if the keeper of the record reasonably believes that the disclosure is necessary to prevent or lessen a serious and immediate threat to the mental or physical health or the safety of the individual who is the subject of the information, another individual, or public health or public safety.

This suggestion resulted in mixed responses. One commentator agreed that in those situations where there is a clear threat to a named third party, these details should be given to the police, similar to a situation where threats are made towards certain people. Other commentators were concerned that the Commission suggestion fails to provide adequate guidance concerning when the limited disclosure of a patient's health record should be made.

In January 2002, new *Sharing of Health Information Regulations*[217] came into effect in Nova Scotia. Among others, these regulations apply to people who are in custody and who are being transferred from a courthouse or correctional facility to a hospital. The transfer must be accompanied by a completed Health Information Transfer from, which would include such details as diagnosis, health care provider, conditions requiring ongoing attention, and medications.

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[215] *In the Matter of an Inquiry into the Cause of the Death of Richard Albert Clarke, on November 10, 1996 at Dartmouth, Halifax County, Nova Scotia* (24 July 1998) (N.S. Prov. Ct.) at 11.

[216] Note 203, above, s. 22.

[217] N.S. Reg. 151/2001.

The Commission is in favour of the *Sharing of Health Information Regulations*. The Commission nonetheless thinks that a provision wider in scope should exist to enable in appropriate circumstances the disclosure of the relevant portion of a patient's health care record.

The Commission remains of the view that its Discussion Paper suggestion concerning limited non-disclosure of a health care record strikes a balance between a patient's right to privacy and the need in certain instances to protect the subject of the record or other people. The Commission also thinks that as set out, the suggested circumstances in which disclosure can be made are sufficiently specific to provide direction, yet are also flexible enough to take into account a variety of facts. The Commission therefore recommends that the disclosure of the relevant portion of the patient's health care record should be possible to any person if the keeper of the record reasonably believes that the disclosure is necessary to prevent or lessen a serious and immediate threat to the mental or physical health or the safety of the individual who is the subject of the information, another individual, or public health or safety.

The Commission recommends:

- The disclosure of the relevant portion of the patient's health care record should be possible to any person if the keeper of the record reasonably believes that the disclosure is necessary to prevent or lessen a serious and immediate threat to the mental or physical health or the safety of the individual who is the subject of the information, another individual, or public health or safety.

2. Accuracy, correction and amendment of health records

Should there be a statutory right to correct or amend health records?

The mental health statutes in the majority of provinces and territories allow people to have information corrected in their health records. These provisions seem to be based on the ULCC *Uniform Mental Health Act*.[218] The Nova Scotia *Hospitals Act* does not include a statutory right of correction or amendment.[219]

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[218] Note 96, above.

[219] The Canadian Medical Association's *Health Information Privacy Code*, note 205, above, also addresses this issue:

Subsection 29(7) of the ULCC *Act* allows a person who is permitted to examine his or her record to request a correction of information in the record, if the person believes it contains an error or omission. If the requested correction is not made, then the person is entitled to have a statement of disagreement attached to the record, reflecting the nature of the correction requested but not made. The person is also entitled to have notice of the correction or statement of disagreement given to any person or organization to whom the record was disclosed within the previous year.

The Commission took the position in the Discussion Paper that in the interest of fairness, those patients entitled to view their mental health care records should be able to indicate their disagreement with any details in the record. As a result, the Commission suggested, the *Hospitals Act* should contain a section equivalent to subsection 29(7) of the ULCC *Act*. This section would permit a patient, otherwise entitled to view his or her record, to require that corrections be made, or statements of disagreement be added, to a record. The section would also require notice of the correction or statement of disagreement to be provided to persons or organizations to whom access to the record had been granted within the previous year.

For the most part, commentary received was favorable. One commentator indicated that as patients have the basic right to review their hospital health record, it was simply consistent that they would be able to inform the hospital in writing about any matters of disagreement. Another commentator indicated, however, that the hospital or health care record may contain items other than direct observation involving a patient and information supplied by the patient. As a result, third party information should be recorded as such.

The Commission affirms its Discussion Paper proposals involving this issue. As a result, the Commission recommends that the *Hospitals Act* should permit a patient, otherwise entitled to view his or her health record, to require that corrections be made, or statements of disagreement be added, to a record. The Commission also recommends that the *Act* should require notice of any correction or statement of disagreement to be provided to persons or organizations to whom access to the record had been granted within the previous year.

7.3 Patients who have reviewed their information and believe it to be inaccurately recorded or false have the right to suggest amendments and to have their amendments appended to the health information.

The Commission recommends:

- The *Hospitals Act* should permit a patient, otherwise entitled to view his or her health record, to require that corrections be made, or statements of disagreement be added, to a record.
- The *Act* should also require notice of any correction or statement of disagreement to be provided to persons or organizations to whom access to the record had been granted within the previous year.

IV SUMMARY OF RECOMMENDATIONS

The Commission recommends that:

III. A. ADMISSION TO MENTAL HEALTH FACILITIES

1. Involuntary examination and assessment [pages 25 - 28]

- The current wording of the *Hospitals Act*, which at subsection 36(2) requires "reasonable and probable grounds" for admission as a person under observation, but a higher standard for admission as an involuntary patient, should be retained.
- The standard time period for completion of a psychiatric examination should not exceed 48 hours.
- An examination should be completed as quickly as possible, in compliance with professional standards.

2. Pursuant to medical certificates [pages 28 - 32]

- The majority of the Commission recommends that the *Hospitals Act* should continue to allow for the involuntary admission of a person for observation on the basis of two medical certificates provided by physicians. Admission for observation should also be possible based upon one certificate where the attending physician is able to justify why only one certificate was used.
- The possibility of detention and examination by authority of a judicial order should be retained.

3. Criteria [pages 32 - 42]

- The term "mental disorder" should be used rather than "psychiatric disorder."
- "Mental disorder" should be defined as a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life.
- The majority of the Commission recommends that the Nova Scotia legislation should allow for the involuntary admission of someone with a mental disorder when "serious harm" is likely to self or others.

- The majority of the Commission recommends that neither harm to property nor finances should be specified as a ground for a person's involuntary admission to a facility.

- The *Hospitals Act* should make clear the need for a causal relationship between a mental disorder and, depending on the standard that is chosen, serious harm or danger to self or others.

4. **Peace officers** [pages 42 - 47]

- Peace officers should be permitted to leave a facility during the time that a person apprehended and brought in by the officers is being examined. To avoid any misunderstandings, consent for peace officers to depart a facility should be in writing.

- Facility staff should be required to inform peace officers prior to discharge when a psychiatric examination of a person brought to a facility by peace officers is completed and the person is not admitted as an involuntary patient. The duty to inform should also apply if the person is admitted. As a matter of consistency, the duty to inform should extend to situations involving the discharge of a person who has been involuntarily admitted, so long as that person had been brought to the facility by the police.

- The majority of the Commission recommends that at clause 38(1)(b) of the *Hospitals Act*, which provides for the apprehension of a disordered person "committing or about to commit an indictable offence," the term "indictable" should be removed.

- Copies of relevant police reports should be included in a patient's psychiatric file.

5. **Detention periods** [pages 47 - 51]

- The current initial detention period of not longer than one month for an involuntary patient should be retained.

- An admission certificate should be renewable for a period not to exceed one month, followed if needed by a period up to two months, in turn followed by a period up to three months. Any additional renewal periods would not exceed three months.

- The responsibility for renewal examinations should remain with psychiatrists.

- Unless no other psychiatrist is available, an examination for the purpose of a renewal certificate should continue to be completed by a psychiatrist who was not involved in the initial admission certificate or a prior renewal certificate.

- Any disputes involving the nature or duration of renewals should be heard by the review board.

B. TREATMENT

1. Mental capacity to consent to treatment [pages 52- 56]

- The *Hospitals Act* should state explicitly that every person is considered capable of making treatment decisions, until the contrary is determined.
- A capacity determination should take place only on an as-needed basis, in accordance with generally accepted medical practices.
- The factors at subsection 52(2) of the *Hospitals Act*, which a psychiatrist must consider in determining a person's capacity to consent to treatment, should remain unchanged.
- In addition to psychiatrists, other specially qualified health care professionals should be permitted to complete capacity assessments. Organizations of health care professionals should determine what combination of training and experience would meet the required qualifications.

2. Informed consent [pages 57- 59]

- The *Hospitals Act* should specify that informed consent involves explaining to a patient the nature of the treatment, its expected benefits, its material risks, its material side effects, any alternative courses of action, and any likely consequences of not having the treatment.
- The elements of informed consent should be set out in any standard forms used in compliance with the *Act*.
- What form consent should take, as well as what would be included as part of the agreed-upon treatment, would remain in accordance with generally accepted medical practices.

3. Consent to treatment and compulsory treatment [pages 59 - 67]

- The majority of the Commission recommends that in those situations for which a person has not appointed a proxy through an advance health care directive, and there is no statutory decision-maker available, it should be possible for a review board to approve compulsory treatment within a facility if the person has become mentally incapable. Before authorization, the review board must be satisfied that the mental condition of the patient will either be substantially improved by the treatment or will not improve without the treatment and that the benefit to the patient will outweigh the potential risk of harm.

- The *Hospitals Act* should define routine clinical medical treatment, with extraordinary types of treatment to be approved by a review board.

- Routine clinical medical treatment should be defined as "generally recognized and acceptable psychiatric treatment and other generally recognized and acceptable medical treatment that is necessary to effectively treat a mental disorder."

- A substitute decision-maker should be required to take into account any prior expressed wishes by a person. If there are no prior expressed wishes, or if they are unclear, then a substitute decision-maker should take a person's best interest into account.

- Best interest should be determined according to:

  i) whether or not the mental condition of the patient will be or is likely to be substantially improved by the specified psychiatric treatment;
  ii) whether or not the mental condition of the patient will improve or is likely to improve without the specified psychiatric treatment;
  iii) whether or not the anticipated benefit from the specified psychiatric treatment and other related medical treatment outweighs the risk of harm to the patient; and
  iv) whether or not the specified psychiatric treatment is the least restrictive and least intrusive treatment that meets the prior three requirements.

- In the event of a dispute between substitute decision-makers of the same rank, either a substitute decision-maker or the treating psychiatrist could apply to the review board, in order to have the dispute resolved.

4. Emergency exception to consent requirement [pages 68 - 70]

- The statute should specifically allow for treatment to be administered in the event of an emergency without consent to a person who is incapable with respect to consent to the treatment.

5. Liability of health care professionals [page 70]

- The *Hospitals Act* should include a section which exempts from liability any person acting reasonably and in good faith in the course of his or her responsibilities under the *Act*.

6. Advance health care directives [pages 70 - 73]

- The majority of the Commission recommends that where a person is no longer mentally capable, an advance health care directive should be overridden, if medical developments, not known at the time of the directive's creation, are sufficiently compelling to justify not following the directive.

7. Provision of mental health treatment in the community [pages 73 - 78]

- Leave certificates should be made available in Nova Scotia for certain involuntary patients.

- In order for a leave certificate to be issued, the patient must be suffering from a mental disorder for which he or she needs continuing treatment or care and supervision while living in the community. The patient must be considered likely, because of the mental disorder, to cause serious harm to self or others, if the patient does not receive continuing treatment or care and supervision while living in the community.

- A collaborative treatment plan must be developed, to which the patient or the patient's representative consents. The patient must be capable of complying with the leave certificate requirements. The treatment or care and supervision described in the leave certificate must exist in the community and can and will be provided in the community.

- Similar to a review of involuntary patient status, the conditions which led to the issuance of a leave certificate are subject to review.

- The duration of a leave certificate should be defined.

C. PATIENTS' PROPERTY AND FINANCES

1. Mental competence to administer one's estate [pages 79 - 81]

- A competency determination should take place only when an issue arises about a patient's competency to administer his or her estate.

- The factors to be considered in determining a person's competency to administer his or her estate should remain unchanged.

- In addition to psychiatrists, suitably qualified health care professionals from outside the psychiatric profession should be permitted to perform competency determinations.

2. **Office of Public Trustee** [pages 81 - 83]

- When the estate of a patient in a facility is in need of supervision and no other person is available, intervention by the Public Trustee should be mandatory. Sufficient resources should be allocated to the Public Trustee's Office to enable it to fulfil its important role with worrying about the ability of some estates to pay.

D. REVIEW AND APPEAL

1. **Composition of review boards** [pages 84 - 85]

- A sitting review board should consist of a lawyer, a psychiatrist, and a lay person.

- Training should be provided for all review board appointees. Training should include an introduction to mental health concepts and issues which might likely arise as part of a review board hearing. Training should also include the requirements of natural justice, fairness, human rights law, and modern caseflow management practices.

2. **Review applications** [pages 86 - 89]

- For the most part, the list at subsection 65(1) of the *Act* of those who can request a review of a patient's file should remain unchanged. The wording should be amended, though, to take into account the fact that there is no "administrator of psychiatric services."

- A patient under the legislated age of majority should also be able to apply for a review.

- In relation to treatment and care, review boards for the most part should continue to provide only non-binding recommendations. A review board should, however, be able to approve compulsory treatment for a person who has not made an advance health care directive, who has become mentally incapable, and who has no available statutory substitute decision-maker. A review board would also have to approve extraordinary types of treatment.

3. Limitation on frequency of review applications [pages 89 - 90]

- One review application should be permitted during the duration of each admission or renewal certificate.

4. Timing of hearing a review application [pages 90 - 91]

- A review board should hear a review application as soon as the board is able to do so and in any event, within 14 calendar days of the application being received.

5. Mandatory reviews [pages 91 - 92]

- There should be a mandatory review, namely a complete review with a full oral hearing, of a patient's file every six months.
- Once undertaken, a mandatory review should be completed as expeditiously as possible.

6. Procedure at review board hearings [pages 93 - 100]

- A hearing should be held whenever a review board considers an application for review.
- The onus of proof during a review board hearing should explicitly be borne by the facility.
- The *Hospitals Act* should define in a general fashion who is entitled to attend a review hearing. The review board should have the discretion to determine whether or not a person has the necessary or legitimate interest in order to attend.
- The patient, the relevant facility, and, if available, the patient's representative, should automatically receive notice of a hearing.
- When a review hearing will involve a minor, notice should be sent not only to the minor, but also to the minor's parents or guardian.
- The *Hospitals Act* should not prevent a review board member from participating in a hearing if he or she has already taken part in a hearing concerning the same patient.

- The wording of the current *Act* at subsection 62(3), which prevents a review board member from participating in the review of a patient, client, or relative of that review board member, should remain unchanged.
- Review boards should provide written reasons with their decisions.
- A decision with reasons should be communicated to the parties involved as soon as possible, and in any event, within five calendar days of the hearing.
- If a review board decision is not provided within five calendar days, then the patient should be automatically discharged.
- The review board should not be empowered to require a patient's appearance at a hearing. The review board should, however, encourage a patient's appearance.

7. **Mandatory legal representation** [pages 101 - 102]

- Mandatory legal representation is not required for patients at a review board hearing.

8. **Right to advocacy services** [pages 102 - 104]

- The *Act* should provide for a rights adviser at each psychiatric facility.
- A rights adviser would be entrusted with the responsibility of explaining a matter pertaining to rights to the best of his or her ability in a manner that addresses the special needs of the person receiving the explanation.
- A rights adviser should be knowledgeable about rights of application to a review board, the nature and procedures of the review boards, and how to obtain legal services. A rights adviser would also require effective communication skills.

E. CONFIDENTIALITY OF PERSONAL HEALTH INFORMATION

1. **Use, accessibility and disclosure of health records** [pages 106 - 113]

- If a facility wishes to deny a patient access to his or her health record, either in whole or part, then the *Hospitals Act* should require the facility to apply for a review board hearing, at which the facility would have to convince the board why denial of access would be reasonable.

- The Public Trustee, as an objective third party, could be called upon to ensure that a patient's interests are protected at a hearing involving the possible denial of access to health information.

- Access to a person's mental health record should in general only be permitted with a person's consent. Subsection 71(7) of the *Hospitals Act*, which allows for the disclosure of general information on the condition of a person or patient unless that person or patient objects, should be retained.

- There is no need to attempt to list all the types of people entitled to general information about a person or patient at a facility.

- The disclosure of the relevant portion of the patient's health care record should be possible to any person if the keeper of the record reasonably believes that the disclosure is necessary to prevent or lessen a serious and immediate threat to the mental or physical health or the safety of the individual who is the subject of the information, another individual, or public health or safety.

2. **Accuracy, correction and amendment of health records** [pages 113 - 114]

- The *Hospitals Act* should permit a patient, otherwise entitled to view his or her health record, to require that corrections be made, or statements of disagreement be added, to a record.

- The *Act* should also require notice of any correction or statement of disagreement to be provided to persons or organizations to whom access to the record had been granted within the previous year.

APPENDIX A

LIST OF SUGGESTIONS FROM DISCUSSION PAPER

Appendix A

List of Suggestions from Discussion Paper

A. ADMISSION TO MENTAL HEALTH FACILITIES

1.
- The current wording of the *Hospitals Act*, which at subsection 36(2) requires "reasonable and probable grounds" for admission as a person under observation, but a higher standard for admission as an involuntary patient, should be retained.
- An assessment should be completed as quickly as possible, in compliance with professional standards.
- The standard time period for completion of an assessment should be 24 hours, with a possibility for an additional 48 hours in exceptional cases.

2.
- The *Hospitals Act* should continue to allow for the involuntary admission of a person for observation on the basis of two medical certificates provided by physicians, or one certificate in compelling circumstances.
- The possibility of detention and examination by a judicial order under the *Hospitals Act*, though not the primary route for admission, should be retained.

3.
- The term "mental disorder" should be used rather than "psychiatric disorder."
- "Mental disorder" should be defined as a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life.
- The Commission seeks comments on what, if any, conditions should be specifically mentioned in the definition of mental disorder.
- The majority of the Commission suggests that the Nova Scotia legislation should allow for the involuntary admission of someone with a mental disorder not only when bodily harm is likely to self or others, but also when there is a likelihood of causing psychological harm to self.

- The majority of the Commission suggests that the statute should include a provision relating to a person's "imminent and serious impairment" as part of the criteria for involuntary admission.
- Neither harm to property nor finances should be available as a ground for a person's involuntary admission to a facility.
- The *Hospitals Act* should make clear the need for a causal relationship between a mental disorder and a danger to self or others.

4.
- Clause 38(1)(b) of the *Hospitals Act*, which provides for the apprehension of a disordered person "committing or about to commit an indictable offence," is not necessary and should be removed.
- Peace officers should be permitted to leave a facility during the time that a person apprehended and brought in by the officers is being assessed. To avoid any misunderstandings, consent for peace officers to depart a facility should be in writing.
- The majority of the Commission suggests that facility staff should be required to inform peace officers when a psychiatric assessment of a person brought to a facility by peace officers is completed and the person is not admitted as an involuntary patient.
- Copies of relevant police reports should be included in a patient's psychiatric file.

5.
- The current initial detention period of one month for an involuntary patient should be retained.
- A declaration of formal admission should be renewable for a one month period, followed if needed by a two month period, in turn followed by a three month period. Any additional renewal periods would be for three months.
- Unless no other psychiatrist is available, an examination for the purpose of a renewal certificate should continue to be completed by a psychiatrist who was not involved in the initial admission certificate or a prior renewal certificate.
- The responsibility for renewal examinations should remain with psychiatrists.

- Any disputes involving the nature or duration of renewals should be heard by the review board.

B. TREATMENT

1. - The *Hospitals Act* should state explicitly that every person is considered capable of making treatment decisions, until the contrary is determined.
   - A capacity determination should take place only when an issue arises about a patient's capacity.
   - The factors at subsection 52(2) of the *Hospitals Act*, which a psychiatrist must consider in determining a person's capacity to consent to treatment, should remain unchanged.
   - In addition to psychiatrists, other specially qualified health care professionals should be permitted to complete capacity assessments. Organizations of health care professionals should determine what combination of training and experience would meet the required qualifications.

2. - The *Hospitals Act* should require that prior to receiving a particular treatment, a patient must provide his or her informed consent. This would mean that the patient was informed about the nature of the treatment, its expected benefits, its material risks, its material side effects, any alternative courses of action, and any likely consequences of not having the treatment.
   - The elements of informed consent should be set out in any standard forms used in compliance with the *Act*.

3. - The majority of the Commission suggests that in those situations for which a person has not appointed a proxy through an advance health care directive, it should be possible for a review board to approve compulsory treatment if the person has become mentally incapable. Before authorization, the review board must be satisfied that the mental condition of the patient will either be substantially improved by the treatment or will not improve without the treatment and that the benefit to the patient will outweigh the potential risk of harm.

- The *Hospitals Act* should define routine clinical medical treatment, with extraordinary types of treatment to be approved by a review board.

- Routine clinical medical treatment should be defined as "generally recognized and acceptable psychiatric treatment and other generally recognized and acceptable medical treatment that is necessary to effectively treat a mental disorder."

- A substitute decision-maker should be required to take into account any prior expressed wishes by a person. If there are no prior expressed wishes, or if they are unclear, then a substitute decision-maker should take a person's best interest into account.

- In the event of a dispute between substitute decision-makers of the same rank, either a substitute decision-maker or the treating psychiatrist could apply to the review board, in order to have the dispute resolved.

4. - The statute should specifically allow for treatment to be administered without consent to a person who is incapable with respect to consent to the treatment if there is an "emergency."

   - An "emergency" should be found to exist if the person for whom treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm.

5. - Restraint should involve keeping a patient under control to prevent harm to the patient or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient.

   - Detailed records should be kept of the type of restraint used. The details, to be made part of a patient's clinical record, should include such information as the date and duration of restraint, the behaviour leading to the use of restraint, and in the event of chemical restraint, the type, administration, and dosage of the chemical used.

   - The *Hospitals Act* should include a clause exempting from liability for the use of restraint any person acting reasonably and in good faith in the course of his or her duties under the *Act*.

6. - The majority of the Commission suggests that where a person is no longer mentally capable, certain compelling circumstances, such as medical developments not available at the time an advance health care directive was created, may justify not following the advance health care directive.

   - The Commission invites comments on what other compelling circumstances might justify not following an advance health care directive.

7. - The Public Trustee's role in relation to consent to treatment could best be considered as part of a project examining all the duties and responsibilities of the Public Trustee.

8. - Leave certificates should be made available in Nova Scotia for certain involuntary patients.

   - In order for a leave certificate to be issued, the patient must be suffering from a mental disorder for which he or she needs continuing treatment or care and supervision while living in the community. The patient must be considered likely, because of the mental disorder, to cause bodily harm to self or others, to cause psychological harm to self, or to suffer imminent and serious impairment if the patient does not receive continuing treatment or care and supervision while living in the community.

   - A collaborative treatment plan must be developed, to which the patient or the patient's representative consents. The patient must be capable of complying with the leave certificate requirements. The treatment or care and supervision described in the leave certificate must exist in the community and can and will be provided in the community.

C. PATIENTS' PROPERTY AND FINANCES

1. - A competency determination should take place only when an issue arises about a patient's competency to administer his or her estate.

   - The factors to be considered in determining a person's competency to administer his or her estate should remain unchanged.

   - In addition to psychiatrists, suitably qualified health care professionals from outside the psychiatric profession should be permitted to perform competency determinations.

2. - When the estate of a patient in a facility is in need of supervision and no other person is available, intervention by the Public Trustee should be mandatory. Sufficient resources should be allocated to the Public Trustee's Office to enable it to fulfil its important role without worrying about the ability of some estates to pay.

D. REVIEW AND APPEAL

1. - The composition of a review board need not be defined in the *Act*.

   - Training should be provided for all review board appointees. Training should include an introduction to mental health concepts and issues which might likely arise as part of a review board hearing. Training should also include the requirements of natural justice, fairness, human rights law, and modern caseflow management practices.

2. - For the most part, the list at subsection 65(1) of the *Act* of those who can request a review of a patient's file should remain unchanged. The wording should be amended, though, to take into account the fact that there is no "administrator of psychiatric services."

   - A patient under the legislated age of majority should also be able to apply for a review.

   - In relation to treatment and care, review boards for the most part should continue to provide only non-binding recommendations. A review board should, however, be able to approve compulsory treatment for a person who has not made an advance health care directive and who has become mentally incapable. A review board would also have to approve extraordinary types of treatment.

3. - The limit on the frequency of review applications should be shortened to three months.

4. - A review board should hear a review application as soon as the board is able to do so and in any event, within 21 calendar days of the application being received.

5. - There should be a mandatory review of a patient's file every six months.
   - Once undertaken, a mandatory review should be completed as expeditiously as possible.

6. - An oral hearing should be held whenever a review board considers an application for review.
   - The *Hospitals Act* should define in a general fashion who is entitled to attend a review hearing. The review board should have the discretion to determine whether a person has the necessary or legitimate interest in order to attend. The patient and the relevant facility would automatically receive notice of a hearing.
   - When a review hearing will involve a minor, notice should be sent not only to the minor, but also to the minor's parents or guardian.
   - A review board may refuse to hold a hearing if a previous application by the same patient was made too recently. Three months should have to elapse between reviews requested by a patient.
   - The law should not prevent a review board member from participating in a hearing if he or she has already taken part in a hearing concerning the same patient.
   - The wording of the current *Act* at subsection 62(3), which prevents a review board member from participating in the review of a patient, client, or relative of that review board member, should remain unchanged.
   - Review boards should provide written reasons for their decisions.
   - A decision should be communicated to the parties involved as soon as possible, and in any event, no later than within 14 calendar days of the hearing.
   - The review board should not be empowered to require a patient's appearance at a hearing.

7. - The Commission invites comments on whether patients should be entitled to mandatory legal representation at a review board hearing, and if so, how this could best be provided.

8.

- The *Act* should provide for a rights adviser at each psychiatric facility.
- A rights adviser would be entrusted with the responsibility of explaining a matter pertaining to rights to the best of his or her ability in a manner that addresses the special needs of the person receiving the explanation.
- A rights adviser should be knowledgeable about rights of application to a review board, the nature and procedures of the review boards, and how to obtain legal services. A rights adviser would also require effective communication skills.

E. CONFIDENTIALITY OF PERSONAL HEALTH INFORMATION

1.

- If a facility wishes to deny a patient access to his or her record, either in whole or part, then the *Hospitals Act* should require the facility to apply for a review board hearing, at which the facility would have to convince the board why denial of access would be reasonable.
- The Commission invites comments on what mechanisms and procedures should be adopted to accommodate both the need for openness and the need to keep certain details confidential.
- Access to a person's mental health record should in general only be permitted with a person's consent. Subsection 71(7) of the *Hospitals Act*, which allows for the disclosure of general information on the condition of a person or patient unless that person or patient objects, should be retained.
- There is no need to attempt to list all the types of people entitled to general information about a person or patient at a facility.
- The disclosure of the relevant portion of the patient's health care record should be possible to any person if the keeper of the record reasonably believes that the disclosure is necessary to prevent or lessen a serious and immediate threat to the mental or physical health or the safety of the individual who is the subject of the information, another individual, or public health or safety.
- The *Hospitals Act* should specifically allow for the disclosure of hospital records and particulars coming within the scope of a search warrant issued to law enforcement authorities.

2. - The *Hospitals Act* should permit a patient, otherwise entitled to view his or her record, to require that corrections be made, or statements of disagreement be added, to a record.

   - The *Act* should also require notice of any correction or statement of disagreement to be provided to persons or organizations to whom access to the record had been granted within the previous year.

3. - Issues involving the ownership and use of personal health care information should form the subject of a separate study.

F. OTHER ISSUES

1. - There is no need to insert general principles, either in the form of a preamble or purpose clauses, into the *Act*.

2. - To promote consistency, clarity, and efficiency in aspects of mental health law, the Commission suggests that changes to the *Hospitals Act* should be undertaken as part of a wider statute which addresses mental health issues generally.

   - If the creation of a wider mental health statute would involve undue delays, then the Commission's proposals should take the form of amendments to the current *Hospitals Act*.

APPENDIX B

LIST OF ADVISORY GROUP MEMBERS
AND
PEOPLE AND ORGANIZATIONS WHO COMMENTED ON DISCUSSION PAPER

APPENDIX B

List of Advisory Group Members And People and Organizations Who Commented on Discussion Paper

(references to positions or organizations are as of the time of a person's involvement or comment)

Members of Advisory Group:

Joanne Bertrand	Executive Director Schizophrenia Society of Nova Scotia
Jean-Pierre Galipeault	Programs Manager Self-Help Connection
Elaine Gibson	Chair, Psychiatric Facilities Review Board
Jean Hughes	Policy Advisor Canadian Mental Health Association, Nova Scotia Division
H. Archibald Kaiser	Professor, Dalhousie Law School
John Murphy	External Consultant Nova Scotia Department of Health, Mental Health Services
Dr. Kim Plaxton	Dalhousie Health Service
Robert F. Purcell	Special Advisor Criminal Operations Branch, RCMP
Sharon Rudderham	Health Director/Advisor Union of Nova Scotia Indians
Loraine Etter	Confederacy of Mainland Micmacs
Estelle Theriault, Q.C.	Public Trustee
Dr. Scott Theriault	Staff Psychiatrist, The Nova Scotia Hospital

Written comments on Discussion Paper:

A number of mental health consumers and family members of mental health consumers

Patricia Bland	Administrator, Scotia Nursing Homes Ltd. Adult Residential Centre
Cynthia L. Chewter	Co-ordinator, Nova Scotia Association of Women and the Law

Dr. Linda Courey	Program Director, Mental Health Services Cape Breton Healthcare Complex
Jeanne Desveaux	Law student and nurse
Jean-Pierre Galipeault	Programs Manager Self-Help Connection
Dr. William G. Gill	Psychiatrist
Elinor M. Grandy	Member of public
John E. Gray, Ph.D.	Manager, Policy and Systems Development, Adult Mental Health Division, B.C. Ministry of Health
Jean Hughes	Policy Advisor, Canadian Mental Health Association
H. Archibald Kaiser	Professor, Dalhousie Law School
Suzanne L. Kennedy	Lawyer
Patrick Lee	Program Director, Mental Health Program IWK Grace Health Centre
John MacDougall	Member of public
Dr. Michael MacKenzie	Physician
Dr. David Mulhall	Psychiatrist
Dr. R.D. Mullan	Medical Director Kings Regional Rehabilitation Centre
Dr. Therese O'Neill	Psychiatrist
Dr. Michael D. Teehan	Psychiatrist
J. Walter Thompson	Lawyer
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Oral comments on Discussion Paper:

A mental health consumer and a number of family members of mental health consumers

John MacDougall	Member of public
Dr. Michael MacKenzie	Physician